			Please Type or Pri State of M 1 - For State Redistrar	laryland / Dep		Health and N	Mental Hyg	_	38501
	Physici		1. Decedent's Name (First, Middle, Last) Virginia Keown Pruett				2. Date of Death Month November	h Day Year	3. Time of Death 3:00A M
	/Medio Examin Funeral Director		4a. Facility Name (If not institution, give street and number Charles County Nursing Red 5. Social Security Number 413-30-3410		La Plat	If Under 24 Hrs.		4c. County of Deal Charles Year) 9. Birl Co	h
	h the Maryland ir 28a-f show	irector	Usual Residence of Decedent	10c. City, Town or La Plata				0g. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 □ No nuntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evantinar must be notified at once.	by Funeral Director	10200 La Plata Road 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 1 □ Ves 2 □ If Yes, Give Year or Dates	No	B. Was Decedent of I	20646 Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- b Rican, etc.)	USA 14. Race - Ame Black, White Specify:	
21215-0036	within 72 ho jiene. r than "natu i r o Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Giv	cedent's Usual Occu ve kind of work done . DO NOT use retire Homema	during most of work d)	king	16b. Kind of Business	
yland	should be filed vind Mental Hygie marked other tumatic event, In	To Be C	17. Father's Name (First, Middle, Last) Marshall Keown			Minni	ne (First, Middle, M Le Adams		
e, e	1 and 2 sh Health and em 27 Is n other traun		19a. Informant's Name/Relationship (Type. Print) Mary Kay George/Daughter 20a. Method of Disposition	111	l87 Captai	ns Walk (Ct. North	City or Town, State, Potomac, N 20c. Location - City or	D 20878
Saltimor	nit. Pages artment of ortant; If Ite Injury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Brinsfie	position (Name of ematory or other place 1d-Echols	Crem.11/	19/09	Charlotte	
ñ	Deprime any onc		23a. Part 1. Enter the disease, or complications that cause	ed the death. Do not e	22. AREHART 211 St.	Mary's Av	e. La Pl	ata,MD 20	Approximate
	Physician /Medical Examiner	_	MILLO	ine. DUIC 1 s a consequence of): DUIC D3	RESTRUCT	TORY INE L	FAILL DI	IERSE	Interval Between Onset and Death
	icate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):					
.O. Box a	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic		2☐ Fetal death 3 at time of death 5	B	су		23d. Date of de Month	livery Day Year
ecords, r	equires that en signed t	δ	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	ven in Part I.		oacco use contribute to es 2 □ No 3 □ P	o the cause of death?
Vital Reco	n; The law re ficate has be r, page 2 sho	Completed	HYPERTENSION					y prior to ned? death? 2 2 No 1 Yes	utopsy findings available completion of cause of s 2 □ No
I A IO U	ling Physicia After this cert uneral directo	on: To Be	27. Manner of Death 1 Matural 5 ☐ Pending (Month, L	tient 2 ER/Outpati jury 28b. Time lay, Year) Injury	of 28c. Inju	ner: 4 Nursing H ry at rk?		e) ence 6 □Other (Spe ow injury occurred	ecify)
DIVISION	al or Attend s after death il Director: ed in by the f	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of I building,	njury - At home, farm, s etc. <i>(Specify)</i>]Yes 2□No	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	he Hospit in 24 hour he Funera ipletely filk	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the besing and manner of the desired forms and manner of the desired forms.	of examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	with To 1	×	29b. Signature and title of certifier		29c. Licen:	2906	2	9d. Date signed (Mon	th, Day, Year)
	Sta	te	30. Name and address of person who completed cause of Louis Kaufman, M.D. 12070 31. Date filed (Month, Day, Year) / 32. Regis		. ,	207 Waldo	rf,MD 2	0602	
	Registr		NOV 19 2009 Senewa &	backer					

Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan	-	artment of I <i>rtificate of</i>		and M		jiene leg. No 20	09	38502
	Physici /Medio		1. Decedent's Name (First, Middle, La. James Edv	st) vard Pil	kerton					2. Date of Dea Nov 15	, 2009	Year	3. Time of Death 4:00 P _M
	Examin		4a. Facility Name (If not institution, giv 17100 Clinto				4b. City, Town, o		of Death	-	4c. Count		George's
	Funeral Director		210 10 0073	ex M 2□ F	7. Age (<i>In yr</i> s.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Day NOV 25	, Year) 1941	9. Birth Cou	place (State or Foreign ntry) nington DC
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George'		ty, Town or Lo							0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	al Director	10e. Street and Number 17100 Clinton	Drive			10f. Zip Code 2060)7		1	Og. Citizen of United		-
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, it a Medical Exaction remains to coffined at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 XYes If Yes, Giv Year or Da	ces?	- 1	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)	14. Ra Bla Specia	ice - Ameri ack, White, fy:	
1215-0	filed within 72 hc Hygiene. vther than "natu ent, Ir e Mesical	Completed	15. Decedent's Ec (Specify only highest gra	lucation ide completed) College (1-	-4or 5+)	(Give life. i	dent's Usual Occu kind of work done DO NOT use retire	during mos d)	t of worki	ng	16b. Kind of E		·
Maryland 21215-0036	Schould be filed within and Mental Hygiene. is marked other than aumatic event, It e Manatic event, It e Manatic event, It e Manatic event.	To Be Co	12 17. Father's Name (First, Middle, Last, Joseph Pill			Sei	rvice Tec	18. Mothe		(First, Middle, I	Maiden Surna		Service
, Mary	and 2 should ealth and Men n 27 is marke ner traumatic		19a. Informant's Name/Relationship (John L. Biggs (N			2805	ng Address <i>(Stree</i> 57 Barley	Run,			el 1997	'3	·
Baltimore,	permit. Pages 1 Department of H Important: If itel any Injury or otl once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	siate _	ee Crem	sition (Name of matory or other pla	lov 23	, 200			on, Ma	ryland
Ba	Depar Impo any Ir		21. Signature of Fundral Service	L M	0015	3 1	Alexandri	a Fer	ry R	oad, Cl:	inton,		6633 01d 20735
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. CO N Due to (c	aused the deat ach line. J CE ST or as a consequence of the conseque	UE puence of):	HEART	FA	HILL	IRE			Approximate Interval Between Onset and Death Prove than Syr
). Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	d23c. If yes, outc	irth 2 ☐ Feta ant at time of o	ancy	□ Ectopic pregnan	су				ate of deliv	ery Day Year
ords, P.O	N requires that the description of the description of the detached should be detached		9 Unknown Part II. Other significant conditions of CHRONIC MY		ath but not res		nderlying cause gi	ven in Part i		1	bacco use cor		he cause of death?
Vital Records,	ician; The law r certificate has be ector, page 2 sh	e Completed by	25. Was case referred to medical					26 Place	of Doath	24a. Was a autops perfor 1 Yes	med? 2 No		ppsy findings available impletion of cause of
Division of Vi	Attending Phys or death. ector: After this by the funeral dir	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of (Monti	h, Day, Year)	28b. Time of Injury	f 28c. Inju	ner: 4 🗆 Nu	ursing Ho	me 5 Resid 28d. Describe h	ence 6 Oto	ırred	fy) al Route Number,
	he Hospital or in 24 hours afte he Funeral Dir ipletely filled in	Medical C	29a. Certifier (Check only one) Certifying Pr 2 Medical Example	nysician: To the niner: On the ba and mann	asis of examina	owledge, deat ation and/or in	h occurred at the to vestigation, in my	ime, date ar opinion, dea	nd place, ath occurr	and due to the deed at the time, of	cause(s) and r	manner as e, and due l	stated. o the cause(s)
)	To the within 2 To the Complei	Z	29b. Signature and title of certifier Java 30. Name and address of person who) (1	1)	n 23a) (Tune		7450		2	29d. Date sign	ed (Month,	
- {	LK IN	13					DET RAI	DHM	5	MARIJIA	211	1201	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 18 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23art11,25,27,28a-f per me, g898,12/18/09dhb Certflicate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JoAnne Paugh November 17, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 125 Walnut Street Friendsville Garrett If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 X F Director 234-62-4387 70 West Virginia Nov. 13 1939 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notlfled at 1X Yes 2 No Directo Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 Walnut Street 21531 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: 3 Widowed 4 Divorced 'natural', White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked otheny any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Dewey Leroy Matthews Melinda Rhodes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Saunders, Daughter P.O. Box 383, Friendsville, MD 21531 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 11/20/2009 Cumberland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine Sweitzer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1634 /Medical Due to (or as a consequence of) Examiner N APROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisass or lighty that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. CERTIFICAT Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA r 28b. Time of Injury 28d. Describe how injury occurred Fell while 28a. Date of Injury (Month, Day Year) 27. Manner of Death within 24 hours arren uses....

To the Funeral Director: After formulately filled in by the funer. 28c. Injury at Work? Certification: Natural 5 Pending investigation being moved from bed to chair **Unknowh**^M 1 ☐ Yes 2 🛣 No 11/09/2009 2 X Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 125 Walnut Street Friendsville, MD determined 4 ☐ Homicide Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, 311 N. Fourth Street, Oakland, MD 21550

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38504 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV 17^{ay} 2009 **JEAN** PALMER 5:45 AM M NORMA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 8. Date of Birth Month, Day, MAR 25, 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Social Security Number ⁴1930 Months Days Hours Min. 176 20 9772 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No SUSSEX SELBYVILLE DE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19975 USA 60 SHADY GROVE #3 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2 No Specify 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE WAITRESS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NO RECORD JULIA WALBACK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 E. RIDGE ROAD, LINWOOD, PA 19061 19a. Informant's Name/Relationship (Type. Print) MARK PALMER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NOV 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SILVERBROOK CEMETERY 2009 WILMINGTON, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MEALEY FUNERAL HOMES PO BOX 2866, WILMINGTON DE 19805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive disease or condition resulting in death) Due to (or as a con equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

show

Director

Funeral

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other tranmatic event, I'm Modical Expression and Item notified at

Pages 1

Maryland 21215-0036

D. O. 8 D.C. D.

/Medical

Physician/Medical þ Completed

and burial-trar attending physician as director, page 2 should Be မှ e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera Certification:

certificate be

P.0.

Records,

Vital

oţ

Division

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

3 Suicide

29a, Certifier (Check only

4 Homicide

6 Could not be determined

29c. License number)0064120 29d. Date signed (Month, Day, Year) 2009

and address of person who completed cause of death (Item 23a) (Type, Print)

Atif Zecs n 31. Date filed (Month, Day, Year) NOV 1 9 2009 AGH 9733 Health Way Drive
32. Registrar's Signature

e Funeral I

the

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Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 8 15 AM Frederick November 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital (alvert Memorial rince Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**₹** M 2□ F Months Hours 0572971961 212-84-9781 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8125 Arbor Way 20736 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or iten
Iny or other traumatic event, the Medical Examiner.
Iny or other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Washington DC Fire Dept Firefighter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victoria Schaeffer Frederick Perry, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other trai Amy Coates/Wife 8125 Arbor Way, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lee Crematory 11/17/2009 Clinton, MD 21. Signatur uneral Service kicensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cholangia Carcino.

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XNo 1 ☐ Yes 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral dire 1 Inpatient ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Cal and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D67594 November 13, 2009

Jew 10

State Registrar

Cheryl Hepp Huspital Road 100 31. Date filed (Month, Day, Year) 32. Registra s Signature NOV 162009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Cleveras

Barker

Prina Fredrick,

200078

Certificate of Death

4b. City, Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

Charles Aloysius Poore, Jr.

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

November 8, 2009 1:30 A M 4c. County of Death Montgomery Birthplace (State or Foreign Country) June 30, 1947 Washington, DC 10d. Inside City Limits 1 ☐ Yes 21 No 10g. Citizen of What Country? United States Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Health Management 20c. Location - City or Town, State Germantown, MD DeVol Funeral Home Approximate Interval Between Onset and Death 23d Date of delivery

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

November 9, 2009

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

Year

Reg. No. 2009

2. Date of Death

38506

3. Time of Death

al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and of in by the funered director, page 2 should be detached for use as the burdar-transit of in by the funeral director, page 2 should be detached for use as the burdar-transit filled in by

To the Hospital within 24 hours a To the Funeral C completely 1+

> State Registrar

Medical

Sayed Elsayyad, M.D., 10110 Molecular Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

determined

4 - Homicide

29b. Signature and title of confifier

NUV

29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D62435

			Please T	ype or Print in Black In		•	
			For State Registrar	State of Maryland / Depa	artment of Health and N <i>rtificate of Death</i>	, ,	0000 0000
			Negistrar Necedent's Name (First, Middle, Last)		- Inoate of Death	2. Date of Death	3. Time of Death
	Physici /Medio		Jordan Scott	Paganelli		Month November	Day Year
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	November	4c. County of Death
			23193 Cherry Hill		California		St. Mary's
	Funeral		5. Social Security Number 6. Sex	M 2□ F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	17 Yrs.		11/14/19	91 California
	yland how		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Mar 3a-f s	Director	Maryland St. Mary'	s California	1		1 ☐ Yes 2 No
	iff th	Dire	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner out the incitified at	eral	23193 Cherry Hill		20619		nited States
"	ter de	Funeral	11. Marital Status 1 Never Married 2 Married 1 Married 1 Married 2 Married 1 Married	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
2-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ration 16a. Dece	dent's Usual Occupation	ing 16	bb. Kind of Business/Industry
121	ithin ne. han "	ď	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of work DO NOT use retired)		
121	filed within Hygiene. other than "		12 17. Father's Name (First, Middle, Last)	Stude		e (First, Middle, Ma	High_School
and	d be f ental I ced or	o Be		11: Im			· ·
Maryland	2 should be filed within and Mental Hygiene. Is marked other than "raumatic event, tre Me.	은	John Ernest Pagane 1 19a. Informant's Name/Relationship (Typ.		ng Address (Street and Number or Rui	enee Chur ral Route Number, 0	
_	12 # d		John E. Paganelli,	Jr./Father 23193	Cherry Hill Cour	t, Califo	ornia, MD 20619
altimore,	ges 1 a If of He If Rem or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dispo			c. Location - City or Town, State
Ë	Pag Iment Iant: I		4 □ Donation 5 □ Other (Specify)	Arlington	National 12/03	/2009 A1	clington, VA
Ball	permit. Pages 1 an Department of Hes Important: If item any Injury or othe once.		21. Signature of Funeral Service Excense		2. Name and Address of Facility Bri	insfield	Funeral Home, P.A.
	GD = 9 0			ield, Jr. M00052 2			
-		8	shock, or heart failure. List only on- Immediate Cause (Final	0.1		or respiratory arres	t, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		o Savod ma		
7	Examiner			Due to (or as a consequence off:			
	B +	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	ecute ind transi	Examine	Cause, Enter Underlying Cause (Disease or injury that initiated events c.				
760,	be executed sician and burial-transit	ial E)	resulting in death) Last	Due to (or as a consequence of):			
687	leath certificate attending physi I for use as the b	dica	d.				
Box (Physician: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of delivery
Ď	death e atte d for	icia	in the past 12 months?	4 ☐ Pregnant at time of death 5 ☐	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		Month Day Year
P.O.	at the de by the tached	hys	9 🗆 Unknown	9 Unknown	_		
Ś	res tha signed be det	þ	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
of Vital Records,	w requir been s should	Completed				1 ∐ Yes	2 No 3 Probably 4 Unknown
Rec	has l	du				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	iclan: The certificate hi ector, page		25. Was case referred to medical				death? ■No 1 □ Yes 2 □ No
Š	ysician: is certific director,	To Be	examiner?	ospital:	Other:	h (Check only one)	ce 6 Other (Specify)
	ding Phys h. After this funeral di	L:	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury		28d. Describe how	
Sion	Attending r death. ector: After by the funer	atic	1 Natural 5 Pending investigation	(Inorial, Day, real) liquiy	M 1 ☐Yes 2 ☐No		
Division	I or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, strabulding, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	Hospital		29a. Certifier 1 Certifying Phys	Internal To the heat of an Invalidate death			
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only one)	iclan: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, dat	e and place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	0110	29c. License number	290	I. Date signed (Month, Day, Year)
	@) CXV	000	H005575	5	11-11-09
	Come		30. Name and address person who cor	mpleted cause of death (Item 23a) (Type,	Print)		
		\begin{align*} \begin	Jennifer Schmidt, 31. Date filed (Month, Day, Year)		nts Lane, Suite 20	5, Leonai	dtown, MD 20650
	Sta Registr			32. Registrar's Signature	4.11		
DHI	MH 17 Bey 1/2		NUV 1.7 C	009 Janua B. A	Tarke .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryla 1 - State of Maryla		ertificate of l		R	eg. No. 200	38508
	Physicia	an	1. Decedent's Name (First, Middle, Last) Amos Landers Pearson				2. Date of Deat Month	th Day 2009 ar	3. Time of Death 5:00 P M
	/Medic		4a. Facility Name (If not institution, give street and number)		4h. City Town, or	Location of Death	MO A EIIID E I	4c. County of De	
	Examin	er	16106 McGregor Drive			rstown		Washi	
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign Country)
	Director		217–30–6617 ^{1⊠M 2□ F} 72	Yrs.	Monato Bayo	Tiouis Willi.	June 7,	1937 Vi	rginia
9	w I		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or	ocation				10d. Inside City Limits
Mond	f sho	tor	Maryland Washington	Насе	erstown				1 □Yes 2 No
d.	r 28a	Director	10e. Street and Number	павс	10f. Zip Code		1	0g. Citizen of What C	Country?
Hirt.	23a o	al D	16106 McGregor Drive		217	40		United S	tates
0	ems.	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13	B. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
9500	permit. Faggs 1 and 2 should be lifed within 72 hours after bean with the waryand Department of Health and Medical lifed within 12 hours after bean 27 as marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once.	by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: Wh	
ָרָהְ מ	natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occup we kind of work done of DO NOT use retired	ation during most of work	ing I	16b. Kind of Busines	s/Industry
V	than "	ld m	Elementary/Secondary (0-12) College (1-4or 5+)		. DO NOT use retired v Leader	d) -		Power Com	nany
V .	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	Crev	v Leader	18. Mother's Name	e (First, Middle, i		party
	ental ked o	To Be	Clifford Pearson			Lana Po	sey	,	
	shoul and M s marl umati	F	19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State	
, Ma	and 2 salth a 127 is er tra		Gladys Diane Pearson / Wife	1610	6 McGregoi	Dr., Hag	gerstown	, MD 2174	0
ore,	ges is tof He lfiten or oth		20a. Method of Disposition 1 Burnel 2 □ Cremation 3 □ Removal from State	b. Place of Dis cemetery, c Resi	position (Name of rematory or other place naven	Nov.	Date 11,	20c. Location - City of	
Baltimor	rtmen rtant: njury	4	4 ☐ Donation 5 ☐ Other (Specify)	Memor:	ial Garden	s 20		Frederick,	
מ	Depar Depar Impor any ir		21. Signature of Fon and Service Licensee]	Kesthawen 9501 Catoc	Funeral S tin Mtn.	ervices Hwy. Fr	, Skkot Co ederick, M	ody P.A. D 21701
П			23a. Part 1 Enter the disease, or complications that caused the d shock, or heart failure. List ally one cause on each line.	eath. Do not e	enter the mode of dyir	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	s C	ANCEL				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a cons	sequence of):					/
20		ĕ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	sequence of):					
7	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events C	,					
Ď,	inicate be executed by physician and as the burial-transit	Exa	resulting in death) Last Due to (or as a cons	sequence of):					
09/89	are be hysici he bu	edical	d						
Š	ding p		IF FEMALE:						
EOX	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	etal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of o	delivery Day Year
j	Attending Prysician: The law requires that the death cert death. *ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use a	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	or deadi	o □ Other (specify) _				
τ. Γ.	ned b deta	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	quires	q pa					1 □ Y	es 2⊠No 3□	Probably 4 Unknown
000	as ber 2 sho	plet					24a. Was a	an 24b. Were	autopsy findings available o completion of cause of
	ate h	Completed					perfor	med? death	es 2 □No
VIIAI	cran: sertific sctor,	Be (25. Was case referred to medical examiner?		To:	26. Place of Deat	h (Check only o	ne)	
5	rnysician: rthis certific ral director,	<u>۲</u>	1 Yes 2€ No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	2 ER/Outpa		4 ☐ Nursing Ho		dence 6 Other (S	pecify)
0	h. After funer	tion	Natural 5 ☐ Pending (Month, Day, Yea		y Wor	k? Yes 2□No	Zou. Describe i	low injury occurred	
DIVISION	Atten	fica	3 Suicide 6 Could not be 28e. Place of Injury - A	t home, farm,			28f. Location (S	Street and Number or	Rural Route Number,
5	s afte	Certification:	4 ☐ Homicide determined building, etc. '(Sp	ecity)			City or Tow	m, State)	
	lo the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 1 ertifying Physician: To the best of my 2 Medical Examiner: On the basis of examend manner stated.						
1	withir To th comp	Me	29b. Signature and title of certifie		29c. Licens			29d. Date signed (Mo	
			> SAHIY_ MO		D43	5813		Nov 9	2009
			30. Name and address of erson who completed cause of death	item 23a) (Typ	pe, Print)				no di minima di managara di ma
	0	J 7	30. Name and address of erson who completed cause of death (Scort WCC: Scort Mo 11112 Men. 31. Date filed (Month, Day, Year) 32. Registrar's S	CAL CAT	ans Ro	STE DO	HALL	nitrour M	10 21742
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0 2009 32. Redistrar's S	griature	harled				

DHMH 17 Rev 1/2001

			State of Maryland	-	ertment of H Stificate of L			_		
			1. Decedent's Name (First, Middle, Last)	061	Tillcate of L		2. Date of De	Reg. No.	2009	38509
	Physicia	an					Month	Day	Year	F.OF B.M
	/Medic		AA. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Novemb		2009 unty of Death	5:35 P [™]
1	Examin	er					'		rederio	12
	Funeral		4221 Ijamsville Road 5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	msville If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		515-34-3290 1뮻M 2□F 72	Yrs.	Months Days	Hours Min.	Aug. 3	0, 193	37 Cali	fornia
	0		Usual Residence of Decedent				1225,5			
	irylar show	_	10a. State 10b. County 10c. City	, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2.☐ No
	Ba-f	Director	Maryland Frederick	Ijams						25.
	ith th		10e. Street and Number		10f. Zip Code				of What Coun	try?
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, it is Midical Eval, in the matter and the	Funeral	4221 Ijamsville Road	2 40.1	2175				Bass Americ	an Indian
	er de item	,Š	11. Marital Status 1 ☐ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No	5. 13. \	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	o Rican, etc.)		Race - Americ Black, White, e	
36	rs aff	by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		I∐Yes 2∭ No	Specify:		Sp	pecify: Wh:	ite
21215-0036	2 hou	ted	15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation		16b. Kind	of Business/Inc	lustry
215	s. n. "n. Madi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	luring most of worl)	king			
21	d with giene	Š	5+	Ma	ster Chi	ef		U.S.	Navy	
9	al Hy al Hy I othe	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle	Maiden Su	rname)	
<u>Va</u>	uld b Ment arked	ဥ	Ralph E. Pearman			Edith	Fortne	r		
Maryland	2 shc and is m	0 =	19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street a					
≥,	and ealth m 27	- 3	Donna Pearman/ Wife		l Ijamsvi	.11e Road				1754
ore	jes 1 t of H if itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	lace of Dispo emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Locat	tion - City or To	wn, State
Ē	trmen tant:		4 □ Donation 5 □ Other (Specify) Sm		rg Cremat		/2009	Smiths	sburg, l	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, I'm Middell Evan, I'm on the natified at once.		21. Signature of Fundry Hygrvic Liberatee		2. Name and Address Obert E.		Son Fu	neral	Homes.	P.A.
_	<u> </u>		Will Agence	6	15 East M	ain Stre	et, Thu	rmont,	, MD 2	1788
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.					errest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Wou	end to.	the he	ead		1	linutes
1	/Medical Examiner		Due to (or as a consequ	uence of):						
		<u>-</u>	Sequentially list conditions, if any leading to make the conditions.	sanna offir						
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury							
<u>,</u>	n and	Exa	that initiated events resulting in death) Last C	uence of):						-
8760,	ficate be executed physician and s the burial-transit	dical	d							
9	tifica ng ph as th									
Вох	leath certifi attending for use as	1	IF FEMALE: 23b. Was decedent pregnant in the cost 12 prorths? 23c. If yes, outcome of pregna		Ectopic pregnanc	u.		230	d. Date of delive	
О.	ed fo	Physician/M	1 Yes 2 No		Other (specify)	,			Month	Day Year
<u>م</u>	at the de d by the a stached i		9 🗆 Unknown				00. Did			and the second
Ś	signed signed be det	2	Part II. Other significant conditions contributing to death but not resu	uiting in the u	nderlying cause give	en in Part I.		\		ne cause of death?
0	w requir s been si should I	g e	Dillo	~	. 1		''	Yes 2	(40 3 1 1 OL	oably 4 Unknown
Vital Record	e law has b	Completed	Post traumatic Stre	55 L	isorde	2	24a. Was	DSV	prior to co	psy findings available mpletion of cause of
=	cate pag	Ö	A STATE OF THE STA				1 □Yes	2 No	death? 1 ☐ Yes	2 X No
<u>≅</u>	hysiclan: The la his certificate ha I director, page 2	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Oth	26. Place of Dea	th (Check only	one)		-
ō	Phys this ral dir	٦.	1⊠ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatier 28b. Time o	1 3 DUA	4 □ Nursing F	lome 5 Res 28d/Describe			5)
n	ding Phy h. After thi funeral	ertification:	1 □ Natural 5 □ Pending (Month, Day, Year)	Injury	Worl	yan ⟨? Yes 2.XNo			the he	ad
S	otten deat ctor: y the	lica	3 Suicide 6 □ Could not be	me. farm. str	W17	100 2/2010	28f. Location	(Street and I	Number or Rura	al Route Number
Division	after after Dire	erti	4 Homicide determined 288. Flace of injury - Arms building, etc. (Specific	11.L	/		T City or 10	wn, State	1221 Ija	msville Kead
	Hospital or Atten 24 hours after deatl Funeral Director: tely filled in by the	a C	29a. Certifier 1□_Certifying Physician: To the best of my kno					e cause(s) a		
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only one) Medical Examiner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occu	urred at the time	, date and pl	lace, and due to	o the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
			1 (Mun Kohner MD)	ME	D37	7197		Noveml	ber 5,	2009
	nul		30. Name and address of person who completed cause of death (Item	n 23a) (Type,						
_\	OHI		Alan Rohrer, 15 West 7th Stree	t, Fre	derick, N	D 21701				
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signal	ture	parke	,				
	Registr	ar	MIN I 1 2009 Lener	w pl.	150 500					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Day Charlotte R. Parker 8-45 AM NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) D A 8. Date of Birth Funeral Hours 107257T924 207-12-0635 85 PA. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Evanium man and a second any injury or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Florida Brevard Indian Harbour Beach 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 School Road 32935 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Director G.C. Murphy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ William Miller Isabella Verrechiea 19a. Informant's Name/Relationship (Type, Print)
Donald Parker So 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 466 Forest Beach Road Annapolis MD 21409 Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Atlantic Crematory 11/09/09 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Annapolis MD 21401 Oats Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Day Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown sate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes ∠ ∠ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv s after death. al Director: After this certificate ha led in by the funeral director, page Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061219 NOVEMBER 08, 2009

State

31. Date filed (Month, Day, Year) NOV 0 9 2009

TARVINDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINGH

4H AROFA BUMC HOSPITAL 301 HOSPITAI DR GLENBURA
32. Registratis Signature
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Registrar

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Physicia	an	Decedent's Name (First, Middle, Las Robert Geo.	orge Port	er			2. Date of Dea Month		Year	3. Time of E	
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		Pentinouva Region	VAL MOURE	CONTE	If Under 1 Year	1/13/2/14/	Doto of Bird	1	lon.		- Familian
Funeral Director		5. Social Security Number 6. S 218-48-6211 1.	EDM 2□ F 7. Age (in yn	s. last birthd d y) Yrs.	Months Days	Hours Min.	8. Date of Birl (Month, Da 09/20	y, Year)	Count	ace (State or try) 1lan d	r-oreign
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10	d. Inside City	y Limits
e Mary Ba-f sh	Director	Maryland Wicomi	co	Salisbu	ry					1 XYes	2 No
filed within 72 hours after death with the Maryland Hygiene. Hygiene, with than "natural", or items 23a or 28a-f show ent, the Modical Examinant to routified at		10e. Street and Number 1014 Adams Ave	., Apt. 2A		10f. Zip Code 2180]	L		10g. Citizen of W USA	/hat Count	ry?	
tems 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race	e - America k, White, e		
urs afte	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Types 2 □ No If Yes, Give Navy Year or Dates:	7	1 □Yes 2 🙀 No	Specify:		Specify	wh	ite	
"natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ring	16b. Kind of Bu	siness/Ind	ustry	
d withir giene. er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		tal clerk			US Post	al Se	rvice	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. In Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination in the Additional Examination of the	To Be (17. Father's Name (First, Middle, Last) George Ray Porte				18. Mother's Nam Katheri	e (First, Middle, ne Eliz	Maiden Surnam abeth Wi	e) 11ouc	jhby	
and 2 sho salth and 1 27 Is ma		19a hformant's Name/Relationship (Michelle Clark/d	Type. Print) aughter		ng Address (Street Applewood					Code)	
Pages 1 and the nent of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content	Hemovai from State		psition (Name of matory or other place y Cremato	i .	Date 1/09	20c. Location -			
permit. Departn Importa any Inju	•	21. Signature of Funeral Service Licen		2	Holloway 501 Snow	Funeral F	lome Pro	ofession	al As	sociat	ion
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw Onset and D	ween
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		teman hig				≥4	ho	
Examiner	<u>-</u>	Sequentially list conditions,	b. Uncontrol	o Hed	Hypertens	134					
oe executed cian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
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certification of the second of	/Med	IF FEMALE:	23c. If yes, outcome of preg	inancy				23d Dat	te of delive	arv.	
t the death by the atter ached for u	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown		☐ Ectopic pregnanc ☐ Other (specify)	y				•	/ear
es the digne	þ	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.		tobacco use cont Yes 2 □ No	ribute to th 3□ Prob		eath? Jnknown
The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the I	Completed							psy prmed2	prior to cor death?	psy findings a	available ause of
ician: 'ertifica	Be C	25. Was case referred to medical examiner?			lou	26. Place of Dear	1 □ Yes th (Check only o		1 □Yes	2 No	
g Physical this ceral dire	ات. 10	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	28b. Time a		4 L Nursing H		idence 6 Oth	_ ' ' '	1)	
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al or At s after d al Direct ed in by	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	I Route Numi	ber,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (nysician: To the best of my k niner: On the basis of exami and manner stated.)
To withi	M	29b. Signature and title of certifier	Colo		29c. Licens	163		29d. Date signe	d (Month,	Day, Year)	
Church S		30. Name and address of person who	completed cause of death (It	em 23a) (Type,		1 5 1		1000			
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	LAH POILC	of Salisk	my mi	2180			
Registr		NOV 122	009 Anna	P. A	ark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month PM Novembe <u>Bruno Ernest Quiros</u> 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Medical Plata Charles (enter la 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Days Hours 6, 1931 Peru October 152-28-1295 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Waldorf Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2254 Mattawoman Beantown Road 20601 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 XYes 2□No Specify: Hispanic Specify: Hispanic 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress +10Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Quiros Mercedes Munar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2254 Mattawoman Beantown Rd. Waldorf, MD. 20601 Guadalupe Quiros/ wife 20c. Location - City or Town, State 20a, Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov.18,2009Glen Bernie, MD. Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 20601 Part 1. Enter the disease, or complica shock, or heart failure. List only one Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final VIE Lome disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 - Ectopic pregnancy in the past 12 months? Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 🗆 No 2 Accident 1 ☐ Yes 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Physician /Medical Examiner death certificate be executed and burial-trai physician the

Box 68760.

P.O.

or Attending Physician: The law requires that the

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Division of Vital Records,

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Physician

/Medical

Examiner

Director

Funeral

Completed

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Funeral

Director

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be rediffical at once.

1 and 2 should be filed within Health and Mental Hygiene.

Pages 1 and 2

21215-0036

Baltimore, Maryland

attending pl certificate has page 2

Physician/Medical Completed by Be Medical Certification: To

director After this funeral dir within 24 hours after death. To the Funeral Director: A filled in by the

25. Was case referred to medical examiner?

27. Manner of Death Natural

> 3 ☐ Suicide 4 Homicide

ts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) locat Soute 208A, Walter AUD 20602

State Registrar

completely

31. Date filed (Month, Day, Year) NOV 18 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 144 PM Evelyn 8 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death 9. Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5/29/1914 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days 1 M 2 YF 95 Virginia 217-36-9677 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Maryland Prince George Brandywine 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 20613 USA 12607 Martin RD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2 No Specify 3 Nidowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Cottage Matriarch 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Simpson George Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12607 Martin Rd, Brandywine MD 20613 Karl Ragsdale/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 11/17/09 Cheltenham MD 4 ☐ Donation 5 ☐ Other (Specify) 401589 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iten important: of the 27 Is marked other than "natural", or Iten in July or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

death with the Maryland

and burial-trai attending physician use signed by t certificate has page After this s after death.

The law requires that the death certificate be executed

or Attending

Hospital

Division or Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months? 1 ☐ Yes 2 ☑ No
1 ☐ Yes 2 No
9 ☐ Unknown

autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referre	ed to medical
1 ☐ Yes 2 1 N	10
27. Manner of Death	
1 Natural	5 Pendin

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 \(\text{Nursing Home} \) 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred Injury at Work? 1 TYes 2 TNo

26. Place of Death (Check only one)

1∐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c.

29b. Signature and title of Certifier delleded

D0052999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10403 Hospital Drive G-06 CLINTON MD20735 RAHIMIAN, NO

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2 2009

Registrar

31. Date filed (Month

Year)

30. Name and address of erson who completed one of death (Item 23a) (Type, Print) RAMIN RIGILI, MI) 10810 DIRNES COUN ROND SUITE 202 GAITHERS BUR, MD 20878

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7, 2009 November Chad George Ranko Medical 12:13 pM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8 Date of Birth 1 🛣 M 2 🗆 F Months Days Hours (Month, Day, July 13 Director 097-56-4663 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is an awked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Md. Prince George's 1 tz Yes 2 No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7302 18th., Ave. 20783 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jim Ranko Rose Demtro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Ranko (Wife) 7302 18th., Ave. Hyattsville, Md. 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery Nov.12,09 Linden, New Jersey Signature of Funeral Service License 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave, Riverdale, Md. 20737 #670 namh Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE MYOCARDIAL disease or condition resulting in death) INFARCTION Medical Due to (or as a consequence of) Examiner ORONARY Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Dav g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURG 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine 1 Yes 2 No ၀ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical

P.O. Box 68760 Records, Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director. Division of Vital 24 hours a

State Registrar 29a Certifier

29b. Signature and title of certifie

31. Date filed (Month D

JOORIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD. FACEP

32. Registrar's Signature

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND

NOVEMBER 9, 2009

29c. License number D40324

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Veronica Rice 1545 Kathleen November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Hours 1170671944 Director Maryland 577-60-7625 65 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director St. Mary's California Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23157 Marble Way 20619 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 K Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 🗆 Widowed 4 🗆 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dunn Ellen. Joseph Starke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23157 Marble Way, California, MD 20619 Harry Rice/Spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Spe 11/16/2009 Hollywood, MD Johns Catholic 21. Si 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sta day Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth
Pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform certificate 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Veronic Records, n leen within 24 hours after death.

To the Funeral Director: After this

State

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

2065

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivia	iryiano / i	•	tificate of l	ieaith and N Death	,	giene Reg. No. 🤈	pnna	38517
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic				Roland				Novembe	r 20,	2009	6:30 a ^M
	Examin	er	4a. Facility Name (If not institution, gi				•	Location of Death		4c. Co	ounty of Death	
مرس			Solomons Nursi 5. Social Security Number 6.5		(In yrs. last bir	rthday)	Solom If Under 1 Year	ons If Under 24 Hrs.	8. Date of Birt	h	Calver	ace (State or Foreign
ı	Funeral Director			1 □ M 2 127 E	82	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Mary	try)
	pu »		Usual Residence of Decedent		10- Oit T							
	aryla shov	ž	10a. State 10b. County		10c. City, Tow	n or Loc	ation				10	0d. Inside City Limits 1 ☐ Yes 2 1 No
	the M	Director	Maryland Calve 10e. Street and Number	rt	L	usby	10f. Zip Code			10= Citizon	n of What Count	
	with with the r		631 San Gabriel	Pond			206	5.7		rog. Citizer	U S A	rry?
	ms 2;	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No	14.	Race - America	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be redified at once.	þ	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 ☑ N If Yes, Give Year or Dates:	lo		Yes, specify Cuba ☐ Yes 2,☐,No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e	
5-0	72 ho	Completed	15. Decedent's E	ducation	16a	. Deced	ent's Usual Occupa	ation during most of work	ina	16b. Kind	of Business/Ind	ustry
2	ithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	O NOT use retired	l)	ing	•		
	filed w Hygie ther ti		17. Father's Name (First, Middle, Last	t)		Н	omemaker	18. Mother's Name	/First Middle		n Home	
and	d be fi	Be (Walter Claude	Lynch				Bessie	Mary	Lyno	. '	
Maryland	should and Mer is marke aumatic	으	19a. Informant's Name/Relationship		19h	Mailing	Address (Street	and Number or Run				Code)
	and 2 sealth ar		Mary Catherine Ro		1	•	,	, Lusby,			own, olaic, zip	oode)
Je,	s 1 a of Hea item othe		20a. Method of Disposition				ition (Name of atory or other plac		Date		tion - City or To	wn, State
Ē	Pages ment of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				e Episco	pal 11/3	0/2009	Vall	ey Lee,	MD
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	ngee	2	22.	Name and Address	ss of Facility Bri	nsfield	Fune	ral Hom	e, P.A.
	20 E # 9	1	Edward N. Brin	sfield, JR	M0005							
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do e.	not ente	r the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
100	Physician		Immediate Cause (Final disease or condition resulting in death)	a Acu	TE C	VA	-					Oriset and Death
	/Medical Examiner			Due to (or as a	consequence	of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a	a consequence	of):						
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events								-	
o,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):			-			
68760	ate br hysici the bu	edical		_ d								
			IF FEMALE:									
Box	death cer	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal death		Ectopic pregnancy	/		23d	I. Date of delive Month	ry Day Year
o.	000	Physician/N	1 ☐ Yes 2 /☐ Ne 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time or death	5 🗆	Other (specify)					
o.	that ned by deta		Part II. Other significant conditions	contributing to death bu	t not resulting in	n the un	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
Records,	The law requires that the ate has been signed by th bage 2 should be detache	ed by							1 □ Y	'es 2 □ N	No 3□ Proba	ably 45 Unknown
000	law re as bee 2 sho	Completed							24a. Was		24b. Were autop	sy findings available
	sician: The law certificate has irector, page 2 a	mo;						·	autop perfoi 1 □ Yes	med?	prior to con death? 1 ☐ Yes	npletion of cause of
Vital	iding Physician: h. After this certifical funeral director,	Be	25. Was case referred to medical examiner?					26. Place of Death			7 103	ZUNO
o to	Physician: this certific ral director,	2	1 Yes 2 No	-	nt 2□ER/Où		3 □ DOA Othe	er: Nursing Ho	me 5 Resid	lence 6	Other (Specify)
	ling F	ion:	27. Manner of Death	28a. Date of Injur (Month, Day)		Time of njury	28c. Injury Work	y at	28d. Describe h	ow injury o	ccurred	
<u>s</u>	teal feat for: the	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 290 Place of Injur	n/ At home fo	rm stra		Yes 2 □ No	OPE Lagretian (C	N	(D
Division	l or Atten after deatl Director: d in by the	Certification:	4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	. (Specify)	iiii, suc	et, lactory, office		28f. Location (S City or To ผ	n, State)	iumber or Hurai	noute Number,
	e Hospital or A		29a. Certifier Certifying Pl	i hysician: To the best o	f my knowledge	e, death	occurred at the tin	ne, date and place,	and due to the	cause(s) an	nd manner as st	ated.
	To the Hospital or Ai within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Example)	miner: On the basis of and manner stat	examination an	nd/or inv	estigation, in my o	pinion, death occur	red at the time,	date and pla	ace, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date s	igned (Month, E	Day, Year)
			1 OX D N	14)			05	58577		Novem	uber 2	0,2009
sel			30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, P	rint)	t 2 1	7	- 1 /	1. 11.0	20678
	Sta		31. Date filed Month, Day, Year)	((AU , M) 32. Degistra	110 M	15/47	al Kd.	1 5/0 /	UNCEF	Malli	IC MY	10018
	Registra	~		009 June	~ B	60	ulas					

DHMH 17 Rev 1/2001

ORIGINAL.

09-09	009)	
Stella	M.	Rowley	

State of Maryland / Department of Health and Mental Hygiene 2009 38518 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 0300 hrs Stella Medical Examiner M. Rowley November 20, 2009 c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Memorial Hospital Cumberland If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Oct 7, 1926 218-16-4821 Director MD 83 2 X F М Usual Residence of Decedent 10d. Inside City Limits 10a. State MD 10c. City, Town or Location Cumberland 10b. County Any Allegany 1 Wes 2 No 28a-f show 23a or 28a-f show Pages 1 and 2 should be filted within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

Int: If item 27 is marked other than "matural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e. Street and Number 66 Boone Street 10f, Zip Code 21502 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces' Never Married 2 Married Yes white 1 Yes 2 No specify: Specify: 3 Widowed Divorced If Yes. Give Yeer item 27 is marked other than "natural", r traumatic event, the Medical Examiner þ 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-52 College (1-4 or 5+) homemaker own home Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname)
Jenny Cosgrove Henderson 17. Father's Name (First Middle, Last) Be ess (Street and Number of Rural Route Number, City or Town, State, Zip Code)
Washington Street Cumberland MD 21502 attornev 19b. Mailing Add 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 11/22/2009 Cremation 3 Removal from State MD Cresaptown Scarpelli Funeral Home, P mportant Donation 5 Other Speoily 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fyneral/Service Lice see the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and cause on the ch lin fariure. List only on 'Medical Death Hypertensive Cardiovascular Disease Complicating Chronic Obstructive Pulmonary Disease Immediate Carre (Fin disease kaminer or condition re-ulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED signed by the attending physician 1 be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown a Linknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions ò ✓ Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been significated as funeral director, page 2 should 1 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; Hospital: 1 examiner? Nursing Home 5 Residence 6 2 V ER/Outpatient 3 DOA Inpatient 2 1 V Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: n 24 hours after death.

E Funeral Director: A etely filled in by the fu 1 V Natural Pending Yes 2 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 20, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Sputhall, MD 32. Registrar's Signature

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38519 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Worth Richard Eugene 3:30 Reichenbach Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
April 2, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 19<u>40</u> 1X M 2 □ F Director 199-32-8778 Pennsylvania 69 Lisual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1

Yes 2 □ No Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 37 W. Bethel St. 21740 U.S.A. Page 1 and 2 should be filed within 72 hours after death went of Heatth and Mental Hygiene.
Int. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Lumber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Irvin L. Reichenbach Mary M. Botts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice E. Reichenbach/Wife 37 W. Bethel St., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important; If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11/21/2009 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Aug disease or condition 34 Medical resulting in death) Due to (or as a consequence of) Examiner char Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year the hed i 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Largup Completed 1 Ayes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsv Buren Perisher Variety this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Gertifying Nurse Practionen To the best of my knowledge, do at the time, data and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D18019 ac no ~ ov 20,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGERSTONN MOZITUD VASKV7 DATTA MILL ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

20 July

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** enous /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** more 01 Wersit ltimone. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Year 1 □ M 2 Months Days Hours Min Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Medical Examinat must be notified as 1 Yes 2 No Director Maryland Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2430 Huntwood Court 21702 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [x] No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or hear any injury or other traumatic execution. 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 21 No Specify 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Wills Yvonne Unglebower ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles William Ridenour / Husband 2430 Huntwood Court, Frederick, Maryland 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 28 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Signature of Funeral Se 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t , page 2 sl autopsy performe Yes 2 certificate 2 X No 1 □Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural death. 2 Accident 1 ☐ Yes within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier CLATRE WATKINS 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 0

State of Maryland / Department of Health and Mental Hygiene 2009 38521 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** November 17, Elaine Saltysiak-Brickett 2009 10:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dennett Road Manor Nursing Home 0akland Garrett If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Director 123-20-4764 10/14/1927 New York Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other than "netural", or items 23a or 28e-f show or other traumatic event, If a Medical Examiner must be notified at 1 Ves 2 No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 N Fourth Street 21550 death by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "netural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor Speech Pathology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ William A. Bottino Frances Guidone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Saltysiak, Son 323 E. Oak Street, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 11/23/2009 Baltimore, MD 22 Name and Address of Facility
David A. Burdock Funeral Home, P.A.
21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine Dweitzer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Meta Corcmon 6000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown sete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 Yes 2 No 1 ☐ Yes : After this certifice funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No the Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by within 24 hours after of To the Funerel Direct completely filled in by 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certilier 29c. License number 29d. Date signed (Month, Day, Year) 012333 1710 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Dr. Thomas G. Johnson, 311 N Fourth Street, Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NUV 1 9 2009 Registrar

			for State Registrar	State of	Marylan	d / Depa	artment <i>rtificate</i>	of H	lealth a D <i>eath</i>	and M	lental Hy	giene Reg. No. 2 (009	38522
	Physici	an	1. Decedent's Name (First, Middle, Margaret T.	^{Last)} Snow							Date of Dea	Day Der 5,		3. Time of Death
da.	/Medic		4a. Facility Name (If not institution,		per)		4b. City, To	own, or	Location of	of Death	Novemir	4c. Count		6:25 p ^M
and it	LAGIIII	CI	Suburban Hospit	al			Bethes	sđa					Mont	gomery
	Funeral Director		5. Social Security Number 578–14–8692	5. Sex 7 1 M 2 K F	Age (In yrs. 95	last birthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Day Oct. 8,	v. Year)	Coul	place (State or Foreign htry) uth Dakota
	ס		Usual Residence of Decedent		140.00									
	f show	ō	10a. State 10b. County	gomery	10c. Cit	y, Town or Lo							1	0d. Inside City Limits 1 □Yes 2 No
	r 28a-	Director	Maryland Mont 10e. Street and Number	gomery		Silve	r Spri					10g. Citizen of	What Cour	ntry?
	23a o		9013 Flower A	venue				209				USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show amy luny or other traumatic event, the flydical Exeminating the notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 🛣 Divorced	12. Was Decedor Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊒X No		Was Decede If Yes, specif 1 □Yes 2		ispanic Orl n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	1	ce - Americ ick, White, fy: Whi	etc.
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21215-0036	within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)		<i>Do Nor use</i> Physic					Med:	ical	
	tal Hyg	BeC	17. Father's Name (First, Middle, La	*			-				(First, Middle,	Maiden Surnai	me)	
Maryland	should be I and Mental s marked o umatic eve	၉	Charles G. Th		n 	405 14-111					.ffith	City on Town	Chada Zia	- Codel
Z Z	and 2 sho lealth and m 27 Is mit her traumi		19a. Informant's Name/Relationship Ann S. Hobb		r						al Route Numbe	-		
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Ħ.	it. Pages rument of literant: If ite	1	4 ☐ Donation 5 ☐ Other (Spe	ecify)	Me	tropol			17	2	2009			Virginia
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in the same	Physician /Medical	6 3	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	ratory as a consequ	Failu	,	or dynn	9,0001140	our diago	or respiratory as			Approximate Interval Between Onset and Death
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ds, P.	uires that t n signed by Id be detac	by	Part II. Other significant condition Myocardial Infa			ulting in the u	nderlying cat	use give	en in Part I.			obacco use cor 'es 2 ½ No		he cause of death?
Division of Vital Records,	law requir as been s 2 should	Completed									24a. Was a		Were auto	opsy findings available impletion of cause of
a B	Physiclen: The lav this certificate has al director, page 2 a	Com									perfor	med? 2 🔼 No	death? 1 ☐ Yes	
Z.	rsicler s certif irector) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 🗆	EB/Outpeties	at 2□ DO4	Othe			n <i>(Check only on</i> me 5 ☐ Resid		han (0	
n of	Attending Physiclen: In death. ector: After this certifica by the funeral director, p	n: Tc	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of		28b. Time o		c. Injury Work			28d. Describe h			iy)
Sio	vttendil death. ctor: A y the fu	catic	2 Accident investigat 3 Suicide 6 Could no	tion			М	1 🗆 \	res 2□i		206 11 (6			10
<u>></u>	al or A s after of I Directed in by	Certification: To	4 ☐ Homicide determin	ed 28e. Place of building	f Injury - At ho , etc. (Specif	y)	eet, ractory, o	office			City or Tow		ber or Hun	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	(Check only 2 Medical Fr	Physician: To the bas caminer: On the bas and manne	is of everning	tion and/or in	westination i	in my or	ninion doa	th occurr	ad at the time	and place	and due t	n the cause/s)
	To the within To the complex c	ž	29b. Signature and title of certifier				29c.	License	number	0/	,	29d. Date sign	ed (Month,	Day, Year)
	20		20. Name and address -forms	D	of do the di	- 02a\ (T	Drint')66	061	5	Nov 6	, 200	7
			30. Name and address of person with	Wb Wb	7 / M	960	o Old	Geo	rgeti	m	Rd, B	etherda	MP	20811
-	Sta Registr	-	31. Date filed (Month, Day, Year)	and manne	istrar's Signa	ture d.	parks	1	•		1			

SNOW, Margaret

			_ FOI	Maryland / Depa					
			= State Registrar	Cer	rtificate of l	Death		.No.2009	38523
	Physicia	an	1. Decedent's Name (First, Middle, Last)	1 0-1 1.			2. Date of Death Month	7, 2009	3. Time of Death
1	/Medic		4a. Facility Name (If not institution, give street and number	lass Schultz	4h City Town or	Location of Death	November	1:10 p M	
	Examin	er	Arden Courts Assisted		4b. Oity, Town, Oi	Potomac		4c. County of Death	omery
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
	Director		114-24-6639 1□ M 2₺ F	77 Yrs.	Moritis Days	Hours Will.	12/17/19:		lew York
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	tor	Maryland Montgomery		S 113	ver Sprin	œ		1 X Yes 2 □ No
	nr 28a	Director	10e. Street and Number		10f. Zip Code	ver bprin		. Citizen of What Cou	ıntry?
	th wit		3005 South Leisure World	Blvd. #124		20906		US.	A
	tems tems	Funeral	11. Marital Status 12. Was Deced Armed Force	ent Ever in U.S. 13. \ es?	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. Ather whaturall, or items 23a or 28a-f show ant, the Medical Examiner must be redflised at any or the Medical Examiner must be redflised at	by F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 If Yes, Give Year or Dat		1 □Yes 2 No	Specify:		Specify:	White
Ö	2 hour		15. Decedent's Education	16a. Deced	dent's Usual Occup			b. Kind of Business/l	ndustry
215	thin 72 e. an "n Medi	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	life I	kind of work done on the contract of the contr	during most of work ()	ing		
21	ed wit ygien ser th	Completed	5+		Atto	rney		La	w
_	0 = 0 \$	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	,	
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinar must be rediffed at	욘	Louis Gla 19a. Informant's Name/Relationship (Type. Print)		an Address (Chrost	and Mumban as Out		nkelstein	To Code
<u>s</u>	nd 2 s llth an 27 is r r trau		Morton Leonard Schultz, h	seband	3005 S	South Lei	sure World g, Maryla	ity or Town State, Z d BIVd. #1 and 20906	24
ē,	s 1 ar		20a. Method of Disposition	20b. Place of Dispo				c. Location - City or 1	Town, State
altimore,	Page nent c int: If	r.	1XI Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)		Gardens	11/10	0/2009	Rockville,	, Maryland
Balt	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature) if runer I Service Licensee	225 ET	Name and Addre	ss of Facility	L DIRECTI	ON, INC. le, Maryl	and 20852
			23a. Part 1. Enter the disease or complications that cau	used the death. Do not ent					Approximate
	Physician /Medical	i i	shock, or heart failure. List only one cause on ead Immediate Cause (Final disease or condition resulting in death)	ehydral	Lon				Interval Between Onset and Death 3 weeks
	Examiner		Due to (o	r as a consequence of):	's de	ement	ia		Years
	D ##	iner	Sequentially list conditions, flary, leading to Innedate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):					
_	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	r as a consequence of):					
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Вох	leath certifit attending p	Physician/Me	23b. Was decedent pregnant	ome of pregnancy rth 2 ☐ Fetal death 3 ☐	∃Ectopic pregnanc	.,		23d. Date of deli	very
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rds,	quires the same an signer turd be d	ρ	Part II. Other significant conditions contributing to dea	un but not resulting in the di	adenying cause giv	en in Part I.	1 ☐ Yes		obably 4 Unknown
Record	law re as be 2 sho	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>=</u>	The cate h	Com					performe	d? death?	2 🗆 No
Vital	siclan; The certificate I rector, page	Be	25. Was case referred to medical examiner? Hospital: Hospital:		100		h (Check only one)		
ö	Phys r this rat dir	.T	1 ☐ Yes 2 1 ☐ In 27. Manner of Death 28a. Date of	patient 2 ER/Outpatier		4 Nursing H	ome 5 Residence	ce 6 ☐ Other (Spec	cify)
o	th. : Afte	tion		, Day, Year) Injury	Worl	Yes 2□No	26d. Describe now	injury occurred	
Division of	or Atter fiter dea Director in by the	Certification: To	3 Suicide 6 Could not be	f Injury - At home, farm, str g, etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	the Hospital or Attending Physician. The law requires that the death certifining 4 hours after death. Inin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending the funeral director. After this certificate has been signed by the attending mpletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only) Certifying Physician: To the base and the	pest of my knowledge, death	h occurred at the til	me, date and place	, and due to the cau	ise(s) and manner as	stated.
	To the H within 24 To the F complete	Medical	one) and manne	er stated.		-			
	5 wit 0 0		29b. Signature and title of certifier Shava R. Mit	talno	29c. Licens	e number 546138		I. Date signed (Month	
	5		30. Name and address of person who completed cause						
	- 1			4816 Physicia		Suite 15	2 Rocky	ille. MD 2	0850
	Sta		31. Date filed (Month, Day, Year) 32. Re	Istrar's Signature	had I	DULLE I.	, LOCK V		- M. W. W.
	Registr	ar	BRUFF E II ZUUN KA	resure a. d	13 Ch 14 14 14 16 16 16 16 16 16 16 16 16 16 16 16 16				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38524 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Рм Jordan Gabriel Stone 2009 6:43 November 5, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1₺ M 2□ F Months Days Hours Min. Director 11/05/2009 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 28a-f MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"——any injury or other traumatic events. Funeral 12379 Silver Rock Circle 20657 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. <u></u> Specify: 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 NA NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Charles Dukes Jennifer Lynn Stone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Stone (Mother) 12379 Silver Rock Circle, Lusby, MD 20657 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols 11/10/2009 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Extoreme disease or condition resulting in death) /Medical Due to (or as a consequence of): Less their Imin Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify). 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? spital or Attending Physician: The hours after death.
neral Director: After this certificate y filled in by the funeral director, pay 2 □ No 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical 29a, Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number D0066650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHU BURRA Edictina

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Records,

of Vital

Registrar's Signature

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year **Physician** Dorothy Louise Stiegleiter November 10, 2009 11:08 a.m /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 23140 Cobblestone Lane, Apt. 404 St. Mary's California 6. Sex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 12/16/1917 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2 🖾 F Country) Illinois 91 **Director** 347-20-4618 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2X No Maryland St. Mary's California 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20619 Funeral 23140 Cobblestone Lane # 404 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: "natural", or it 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 21 No Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Logue Ruth George Μ. 0gg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry F. Stiegleiter/Spouse 23140 Cobblestone Ln, #404, California, MD 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols 11/13/2009 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) THEROSCIEROTIC CAMMO MEN AND INVERCE **Physician** /Medical Due to (or as a consequence of): **Examiner** YEARS moundes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) signed by the a o 9 Unknown 9 Unknown ۵. Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the i 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 MD 160-96 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. Gill, M.D. 24035 Three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:20 p 2009 November William Sorrells, Jr. Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's 44625 Deer Field Road Callaway If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ▼ M 2 □ F Yrs 02/08/1920 89 Georgia **Director** 259-18-5438 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Maryland Examination to inviting at any injury or other traumatic event, It a Maryland Examination to inviting at any once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 Tx No Director St. Mary's Maryland Callaway 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20620 USA 44625 Deer Field Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ★ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2K No Specify. Specify ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Translator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Corene Brown Sorrells, Sr. William Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen Sorrells-Bean/Daughter P.O. Box 61, Callaway, Maryland 20620 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 11/05/2009 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Kyle S. Simons M01206 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiopulmonary Arrest months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury Lim to for as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Year Month Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed yes 2 No this certificate 1 🗆 Yes Hospital or Attending Physician: 26. Place of Death (Check only one) completely filled in by the funeral director, Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manyler of Death (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number D42597 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 26840 Point Lookout Rd., Leonardtown, MD 20650 Jeffrey C. Brown, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38527 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Francis Allan Swann 13. 2009 11:24 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 8. Date of Birth (Month, Day, Y March 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Mary Land . 1957 Director 52 216-70-9714 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Mary's Maryland Chaptico 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36570 Notley Hall Road 20621 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electric Company Instrument Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev once. ည Francis Gwynn Swann, Jr. Catherine Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Bailey Swann / Mother 22251 Colton Point Road Bushwood, MD 20618 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State November 17, 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 2009 Bushwood, Maryland 21. Sayar re of Funeral Service Li 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. schere 41590 Fenwick Street P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) JORN Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be emie 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No Yes 2 1 L Yes the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Inpatient 2 ER/Outpatient 3 DOA 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) ၉ 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) equava town 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Leroy Spalding, Sr. P_{M} ray, November 2009 5:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Months Hours (Month, Day, Year) October 29,1922 219-16-1942 Director Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland St. Mary's Mechanics ville 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 26190 Morganza Turner Road 20659 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working State Highway life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other this any njury or other traumatic event, the 1 angles. Heavy Equipment Operator Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 George Spalding Mary Louise Raley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Alberta Spalding / Wife 26190 Morganza Turner Road Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 18 cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Morganza, Maryland 21: Signature of Funeral Service Licensee 22. Name and Address of Facility Tichael 7 Mattingley-Gardíner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 brown 23a. Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ arrhyth Cardine disease or condition ecun 31 Medical resulting in death) Due to (or as a consequence of) **Examiner** myocardial ルシュートロ Sequentially list conditions, if any, leading to immediate cause. Litter underlying Examiner Due to (or as a consequence of): the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) arten 1) SSCONL attending physician and for use as the burial-tran Years resulting in death) Last Physician/Medical . Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ➤ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The 24 hours after deatn.

2 hours after deatn.

3 Funeral Director: After this certificate hat funeral director, page 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practicular: 1. In South Computer States and place, and due to the cause(s) and maliner stated. (Check within 2 Signature and title of certifier 29d. Date signed (Month, Day, Year) phy 51 (362 H63519

Registrar
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A. park

25500 point lookers Rd

32. Registrar's Signature

Leonardton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Tucker

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 09 Physician/ ricia 2049 M On Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 05 5 ound eonar Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Days Hours (Month, Day, Yea 218-32-8150 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits St. Mary's Maryland Avenue 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37641 Louis Bailey Road 20609 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ° Elementary/Seconday (0-12) College (1-4 or 5+) Officer's Club 8 Sous Chef Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Louis Bailey, Sr. Marion Rae Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37641 Louis Bailey Road Elmer G. Spalding, Sr. Avenue, MD 20609 /Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 K Burial 2 Cremation 3 Removal from State November Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206. Leonardtown, MD 20650 23a. Part 1.(Enter the disease, or complidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final metantains Physician Liver Cance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner potension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Ribr, lation Hospital or Attending Physician: The law requires that the death certificate be executed Spalding ing physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ Ł 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be (25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+. 31. Date filed (Month, Day, Year) State Registrar NOV

Patric

Marion

			For State	State of M	laryland	-	artmen <i>rtificat</i>				1ental Hy	_		009	38	531
			Registrar 1. Decedent's Name (First, Middle	a Last)			Tincat	OI L	Jeani		2. Date of De	Reg. No	o. 6 '	000	3. Time of D	
	Physicia	an .		,,	1						Month	Da		Year		Jean M
	/Medic		Richard Bren 4a. Facility Name (If not institution	<u> </u>			4h Cibu	Ta	1	of Dooth	Novemb			2009 y of Death	1702	
	Examin	er	21924 Rosewood		,				Location							
	Funeral		5. Social Security Number		ge (In yrs. la	st birthday)	If Under	_	n Par		8. Date of Bir		L. M	lary's	lace (State or	Foreign
	Funeral Director		529-70-5953	1 X M 2 □ F	60	Yrs.	Months	Days	Hours	Min.	(Month, Di	ay, Year		Cour	itry)	, oroign
			Usual Residence of Decedent		00		L				00/10/	1747	,	Utah		
	hours after death with the Maryland tural", or items 23a or 28a-f show al Evarring in ust be notified at		10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City	/ Limits
	a-fs	Director	Maryland St. Ma	ry's	Lexi	ngton	Park								1 ☐ Yes	2 XNo
	n the	ire	10e. Street and Number				10f. Zip	Code		<u> </u>		10g. C	itizen of	What Cour	try?	
	h wit		21924 Rosewood	l Terrace			206	53				Uni	ted	State		
	deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces		. 13.			ispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)		14. Ra	ce - Americ	an Indian,	
۰	after or ite	II.	1 ☐ Never Married 2X Marr	ied 1 X Yes 2 ☐		į.	1 ☐ Yes		Specify:		nican, etc.)			ack, White,	etc.	
\mathbb{S}	ral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates			I L 162	ZKINO	Specify.	•			Specia	fy: Wh	ite	
9500-612	72 hc	etec	15. Decedent	t's Education		16a. Dece	dent's Usu kind of wo	al Occup	ation	st of worki	ina	16b. I	Kind of E	Business/In	dustry	
7	within 72 lene. than "na"	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,.g					
N .	ed w tygiel nt, th	S		4		Reta	il Sa	lesm						prove	ment_	
yland	2 should be field within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the "sedical Evaning nust be notified at	Be	17. Father's Name (First, Middle,	•					18. Mothe	er's Name	e (First, Middle	, Maide	n Surnai	me)		
<u>\</u>	ould Mer arke	은	Richard Rollins						Shir	ley	June Ho	1st	en			
Z Z	2 sh l and ls m		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address	s (Street a	and Numb	er or Rur	al Route Numb	er, City	or Town	n, State, Zip	Code)	
2	and lealth m 27		Connie Shepherd	l/Wife		21924	Rose	ewood	l Ter		, Lexir					53
0	Jes 1		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from State	20b. Pla	ace of Dispo metery, cre	osition <i>(Nar</i> matory or d	me of other plac	e)		Date	20c. l	ocation	- City or To	wn, State	
altimore,	men ant: ury		4 □ Donation 5 □ Other (S			yland	Veter	rans	Cem 1	11/24	/2009	Che	1ten	ham,	Maryla:	nd
<u> </u>	permit. Yages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service	Licensee /	Summe	2	2. Name ar	nd Addres	s of Facili	ity Br	insfie	ld F	'une	ral H	ome, P.	Α.
מ	20 5 % 3		Kyle S. Simon	ns M0120	6		22955	Hol	1ywoc	od Rd	l., Leo	nard	ltown	n, MD	20650	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death.	Do n	ter the mod	de of dyin	g, such as	s cardiac	or respiratory a	arrest,			Approximate Interval Betw	een/
F	hysician		Immediate Cause (Final disease or condition	111	MA	('	1111	01							Onset and D	eath
	/Medical		resulting in death)	a. Due to (or a	s a coyse que	ence of):								-		
	xaminer		Constant list on diving	b	U											
	. +	ner	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a conseque	ence of):										
	nd	Examine	Cause (Disease or injury that initiated events	C.												
์ כ	an a	Ä	resulting in death) Last	Due to (or a	s a conseque	ence of):	_									
8/60,	icate be executed physician and the burial-transit	dical		d												
۽ م	cerunca ding ph	Med	IC CENAL C									-				
o i	attending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			☐ Ectopic p	aroan an a	,				23d. Da	ate of deliv	ery	
n .	ne att	icis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant	at time of de		Other (sp						M	lonth	Day Ye	ear
5	by th	hys	9 ☐ Unknown	9 LI OIIKIIOWII												
'n.	w requires that the death sbeen signed by the atter should be detached for u	by P	Part II. Other significant condition	ons contributing to death	but not result	ting in the u	nderlying c	cause give	en in Part I	l.	23e. Did	tobacco	use cor	ntribute to t	ne cause of de	eath?
Hecords	quire en siç uld b										124	Yes 2	2 □ No	3☐ Prof	ably 4 🗀 U	nknown
ည သ	s be	Completed									24a. Was	an	24b.	. Were auto	psy findings a	vailable
	ate has b	E C									auto		1	prior to co death?	mpletion of ca	use of
VITAL	ifficat or, pe	ပ္	25. Was case referred to medical						00 DI				0	1 ☐ Yes	2 □ No	
> :	riystcian: The law r this certificate has b ral director, page 2 st	o B	examiner?	Hospital:	tiont 2 🗆	P/Outnatio	nt 2 🗆 D	OA Othe	35.		h (Check only					
	ar this	\vdash	27. Manner of Death	28a. Date of In	tient 2 □ E jury :	28b. Time o			7 🗀 🕦		me 5 Res 28d. Describe				y)	
ם ו	tune fune	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month, E	lay, Year)	Injury	м	28c. Injur Work 1 □	{? Yes 2 🗆		234. 20001120	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ary 0000	.,,,,		
VISION	Attending ir death. ector: After by the funer	Certification:	3 ☐ Suicide 6 ☐ Could r	not be	niury - At hon	ne, farm. st					28f. Location	Street	and Num	ber or Rum	I Route Numb	ner
2	n b fer	i.	4 ☐ Hornicide determ	ined 28e. Place of I	etc. (Specify)	,, 00	,	,,			City or To			or ridic		
ב ב	w D :-															
ב	e nospilar of Attending Fil 124 hours after death. e Funeral Director: After th letely filled in by the funeral	dical Ce	29a. Certifier Certifyin	ng Physician: To the bes	t of my know	rledge, deal	th occurred	at the tir	ne, date a	nd place	and due to the	Cause	(s) and n	manner as s	stated.	

State Registrar

31. Date filed (Month, Day, Year)

Jennifer Schmidt

NOV 20 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Ln., Leonardtown, MD 20650 Registrar's Signature

29c. License number H0055751

29d. Date signed (Month, Day, Year) 11-18-09

	1	For State Registrar		Sta	te of M	larylan	-	artment o rtificate d		alth and M ath	ental Hy		200	19	38	531
		Decedent's Name	e (First, Middle	e, Last)				·····oato c			2. Date of D	eath			3. Time of	
Physiciar /Medica		LOMA R S	TINTON								NOVEM	BER 1		ear 9	8:30	A M
Examine		4a. Facility Name (/	f not institution	n, give street a	and number	r)		4b. City, Tow	n, or Loc	cation of Death			County of			
		CAROLINE						DENT					ROLIN			
Funeral Director		5. Social Security N 236–36–2 .		6. Sex 1 X M 2		ge (In yrs.	last birthday) Yrs.	Months Da		Under 24 Hrs. lours Min.	8. Date of Bi (Month, D	Dav Year)		Birthpl Coun: EOR		or Foreign
and w	-	Usual Residence of 10a. State	Decedent 10b. County			10c Cit	ty, Town or Lo	cation						10	d. Inside Ci	tv Limits
f sho	_	MARYLAND	TALBO	\m \										1,	1 ☐ Yes	
the N	× -	10e. Street and Nur		71			IAMTTIV	10f. Zip Cod	de			10g. Citi	zen of Wha	t Count	try?	
h with		22380 PO	r pir r	ROAD				2167	76			IINTT	ED ST	ኒ ኒ	c	
ter deat	Funeral	11. Marital Status		12. Wa	s Deceden		.S. 13.	Was Decedent	of Hispar	nic Origin? (Spe lexican, Puerto	ecify Yes or N		14. Race - Black, \	America	an Indian,	
filed within 72 hours after death with the Maryland Hygiene. The Maryland street is 23a or 28a-f show ent, the Medical Evaniner must be realised at	by FC	1 Never Marri		ied 1 T	Yes 2 ☐ es, Give	No 19	1.6	1 □Yes 2 🗶		pecify:	riican, etc.		Specify:			
"natural", or			15. Decedent	t's Education	ar or Dates:	:	16a. Dece	dent's Usuai O	cupation	n		16b. Ki	nd of Busin	ess/Ind	ustry	
nin 72	ber	(Spec	ify only highes	st grade comp	oleted) llege (1-4or	5+)	(Give	kind of work do DO NOT use re	ne durin	ng most of worki	ng				,	
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be file d oth event	Re	17. Father's Name							18.	. Mother's Name	•	e, Maiden	Surname)			
should be and Mentai a marked o	으	HENRY :					T			ANNIE I						
12 h 2 7 kg		19a. Informant's Na								Number or Rura			r Town, Sta	ate, Zip	Code)	
	-	ELIZABET 20a. Method of Disp		CONTAIN	Œ	20b. F	Place of Dispo	sition (Name o	f	TMAN, MI	216/0 ate		cation - Cit	y or To	wn, State	
Pages nent of int: if its		1 X Burial 2 [4 □ Donation			I from State	9		natory`or other EMETERY		NOV 1	A 2000	C TP	WY CIT	A TOT C	S MD	
permit. Pages Department of Important: If it any Injury or o		21. Signature of Fu				UL	2	Name and A	dress of		0,2009				-	- A
89528	_	Kab	th	040			20	O SOUTI	HAI	RRISON :	ST., E	ASTON	, MD	216	01	· A.
			rt failure. List	complications only one caus	s that cause se on each	ed the deat line.	h. Do n oten	ter the mode of	dying, sı	uch as cardiac o	or respiratory	arrest,			Approximat Interval Bet Onset and I	ween
Physician		Immediate Cause disease or condition resulting in death)	(Final on	a	INPR	er772	SACI	1/ D	reub	1741					L CCK	Call
/Medical Examiner		rooming in dodding			Due to (or a	s a conseq	uence of):								Das	. 1
	ē	Sequentially list con	nditions, mediate	b	Due to (or a	s a conseq	uence of):								77	
cuted id ansit	Examine	Sequentially list confrant, leading to imcause. Enter Under Cause (Disease or that initiated events	rlying injury													
e exe	ן נג	resulting in death) I	Last	Ü	Due to (or a	s a conseq	uence of):									-
licete be executed licete be executed physician end sthe burial-transit	dical			d												
ding page as	Me	IF FEMALE:		220 If v	ioo outoom	o of progn	2201									
leath certifi attending for use as	cian	23b. Was decedent in the past 12	months?	1 [res, outcom □ Live birth □ Pregnant	2 🗆 Feta	al death 3[☐ Ectopic pregr ☐ Other (specif					23d. Date of Month		•	Year
Attending Physician: The law requires that the death certificaters. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown			Unknown											
s that gned t	호 조	Part II. Other signif	ficant condition	ons contribution	ng to death	but not res	ulting in the u	nderlying cause	given in	Part I.	23e. Did	l tobacco ι	use contribu	ute to th	e cause of	death?
w requires been sign should be		Cenebra	V9380/1	N Arc	i winT	(1	CISHT	paries	1/19	tem march	1]Yes 2	□ No 3[☐ Prob	ably 4	Unknown
law ras be	Completed	/^	1 200	0/				, 			24a. Wa	opsy	24b. We	re autop	psy findings	available
The l	5										per 1 □ Yes	formed?	dea	th?	2. No	
sician: Th certificate rector, pag	Re	25. Was case refer examiner?		Hospita	ŀ				26. Other:	. Place of Death	(Check only					
This raid dia dia	<u> </u>	1 ☐ Yes 2. ☐ 27. Manner of Deat			1 ☐ Inpar		ER/Outpatie 28b. Time of	III JUDOA	Injury at	4 Nursing Ho	me 5 Res 28d. Describe		6 Other	(Specify	0 //01/	116
ndIng Ith. :: Afte e fune	Certification:	1- Natural 2 □ Accident	5 ☐ Pendin investig	g l	(Month, D	ay, Year)	Injury	2.53	Work?	2 🗆 No	Edd. Describe	o non injui	y occurred			
Atternation of the py the py the	22	3 ☐ Suicide 4 ☐ Homicide	6 Could r determ	not be lined 28e	. Place of Ir	njury - At h	l ome, farm, st fv)	reet, factory, off	ice		28f. Location	(Street an		or Rura	i Route Nun	nber,
ital or rai Dir	Sel				bulluling, c	Sto. (Opcon					Ony or 10	Own, Otate	·/			
To the Hospital or Attending Physici within 24 hours after death. To the Funeral Director: After this cer completely filled in by the funeral director.	edical	29a. Certifier (Check only one)	1 Certifyin 2 Medical	Examiner: O	n the basis	of examina	owledge, dea ation and/or in	th occurred at the occurred at	ne time, o my opinio	date and place, on, death occur	and due to the	ne cause(s e, date and) and manr d place, and	ner as s d due to	tated. the cause(s)
Fo the vithin to the comple	Me	29b. Signature and	title of certifier		nd manner s	stated.	21.	29c. Lie	cense nu	ımber		29d. Da	te signed (/	Month,	Day, Year)	
L > F 0		1	Elm		///		to a	17	314	66		//	14/	29		
	-	30. Name and addr	ress of person	who complete	cause of	death (Iter	n 23a) (Type,	Print)				-//	11 "	-/-		
RK4		DR. LUDW			50	3 CYN	WOOD I	RIVE, 1	AST	ON, MD 2	21601					
State Registra	e r_	31. Date filed (Mon	NOV ()	4 2009	32. Regis	trar's Signa	d. A	failed								
3,000					1		, "									

38532

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** JUNE SALLADA 12:00 P M NOVEMBER 1. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Voor 1 □ M 2 XF Months Days Hours Yrs Director 198-10-2945 MARYLAND AUG 24, 1919 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho Director 1XYes 2 No MD TALBOT EASTON 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 700 PORT STREET, COTTAGE 330 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. Specify: ģ 3 ▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY LOAN COMPANY should be filt.

Alth and Mental Hv.

7 is mark-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD JAY MATTHEWS PAULINE TURPIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If Item 27 is r any injury or other traur CAROL S. MARVEL/DAUGHTER 606 WAYSIDE AVENUE, EASTON, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 11/04/2009 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature Amneral Service Licen 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a, Part. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final terval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and leave the line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 mor Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ Ö the 9 Unknown σ. ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 2 100 Hospital or Attending Physiclan: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Fother (Specify) HOSPICE 1∐ Yes 2 10 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Mann of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide م 24 hou the Funeral Dire cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name ss of person who completed cause of death (Item 23a) (Type, Print) KATHRYN HELSABECK 555 CYNWOOD DRIVE EASTON, MD 21601

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

32. Redistrar's Signature

			1 - State Registrar 1. Decedent's Name (First, Midd		Maryland	l / Dep <i>Ce</i>	artment ertificate	of H	ealth a		2. Date of Dea	eg. No. th		3. Time of Death	
	Physic /Medi	al	LOLA MAE SY		(har)		4b. City, T	-	Lanation	of Dooth	1 ^{Month} 21	_) 9 Year	2:35P	
	Examir	er	4a. Facility Name (If not institution SOLOMONS NUI	-			SC	DLON	IONS				LVERT		
	Funeral Director		5. Social Security Number 203-10-8598	6. Sex 1 M 2 XF	7. Age (In yrs. Ia 90	st birthday Yrs.		Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Day 10-13-	1919	9. Birt PA	hplace (State or Foreignitry)	
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD • CALY		T NORTH BEACH							10d. Inside City Limit Y Yes 2 □ N			
:	3a or 28s	i Director	10e. Street and Number 8933 CHESAI	PEAKE AVE			10f. Zip 0	10f. Zip Code 20714					en of What Co	Country?	
36	within 72 hours after ceant with the maryland and than "natural," or liems 23a or 28a-f show he Macleal Examiner must be neitified at	by Funerai	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	rried Armed Fore	Vas Decedent Ever in U.S. med Forces? Tyes 20 No Yes, Give A		Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri				ecify Yes or No-Rican, etc.)		Black, Whit	e, etc.	
21215-0036	"natura	Completed	15. Deceder (Specify only highe	nt's Education ast grade completed)	Education 16. grade completed) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING AIDE 18. Mother's Name			g	16b. Kind	t of Business/	Industry	
N .	be filed within 72 ha tal Hygiene. d other than "natu event, the Madical		Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle,										NURSING HOME		
\subseteq	permit. Pages 1 and 2 should be till permit. Pages 1 and 2 should be till important: if item 27 is marked out any injury or other traumatic even once.	To Be	AMOS SHEARI								LBRAIT		umamej		
Mar		·	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 12950 LEMAN LANE WALDORF, MD. 2												
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3	3 □Removat from S	state ce	metery, cre	osition (Name omatory or oth	her plac					cation - City or Town, State		
Balti	Departm Departm importal any inju		21. Signature of Funeral Service		479	-	Name and	Addres	s of Facilit	ERAL	SERVI	CE.E	•		
F	hysician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on ea	used the death.	Tu					ND 206 respiratory arr			Approximate Interval Between Onser and Death	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (d	я ве в волеоди	snew of):									
8/60,	physician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	c. Due to (d	or as a conseque	ence of):									
O. BOX 08	the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 275 No. 9 □ Unknown		nth 2 ∏ Fetal o unt at time of dea	death 3	□Ectopic pre □ Other <i>(spe</i>					23	d. Date of del Month	ivery Day Year	
ν, T	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									,			
Der ,	ate has b	Completed	0'								24a. Was a autops perfor	sy	prior to death?	itopsy findings availab completion of cause of 2 No	
VII d	this certificate	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only or				
0	fter this	ation; To	1 Yes 2 No 27. Manner of Death Death Death 1 Pendi	28a. Date of		R/Outpatie 28b. Time Injury		ic. Injury Work	DOTTAL	2	e 5 🗌 Reside 8d. Describe h			cify)	
	after death. Director: After in by the fune	ertifica	2 Accident Invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	of Injury - At hon g, etc. (Specify)	ne, farm, s					28f. Location (Street and Number or Rural Route Nu City or Town, State)				

To the Hospital or Attending Physician: The la within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2

Medical Certification; To

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

H Blattau; MD 110 1705pi;

State Registrar GWYNeth B 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

U

10f. Zip Code

1 ☐ Yes 20 XNo

16a. Decedent's Usual Occupation

FASHION SALES

12200

20601

(Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DOROTHY LOUISE FLY

PEABODY LANE CHARLOTTE HALL, MD 20622

10g. Citizen of What Country?

U. S. A.

14. Race - American Indian.

Specify: WHITE

DEPARTMENT SALES

16b. Kind of Business/Industry

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

WALDORF, MARYLAND

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show rrat", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 : If Item 27 Pages 1

Physician

/Medical

Examiner

Director

Funeral

<u>ک</u>

Completed

Be

ဥ

10e. Street and Number

11. Marital Status

2812 TRUMPETER COURT

15. Decedent's Education (Specify only highest grade completed)

HARVARD PAYSON SMITH

19a. Informant's Name/Relationship (Type. Print)

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondary (0-12)

WANDA H.

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Funeral

Director

Physician /Medical **Examiner**

The law requires that the death certificate be executed and the burial-tran attending physician for use as the buria ned by the a iis certificate has been signed director, page 2 should be det

Division of Vital Records, P.O. Box 68760,

20b. Place of Disposition (Name of cemetery, crematory or other place) NOVEMBER 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. OAKLAND CEMETERY 29,2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 23a. P. rt1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading Limited all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ Completed 1 □ Yes Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 1 | Yes 2 | ■ Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural ■ 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature

College (1-4or 5+)

PINGITORE/FRIEND

M00641 5635 WASHINGTON AVE., LA PLATA, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No robably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

C

Mr

Funeral Director

or Items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumetic event, the Wedfoal Evant and Landblined at once.

		Please				delible lnk			_		_	ble.					
	For State Registrar		State o	f Marylar		artment of hartificate of		and N	-	-	-	N 9	385	35			
in	1. Decedent's Name	JANE S							2. Date of De NOV • 2	eath		Year	3. Time of De 6:05P	eath M			
aı er	4a. Facility Name (//	f not institution, g				4b. City, Town, o	LOCATION C			C	County						
	5. Social Security N 578-82-9		Sex 1□M X F	7. Age (In yrs. 47		Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 7 – 22 –	rth ay, year 196	2	9. Birthp	lace (State or F try)	oreign			
ctor	Usual Residence of 10a. State MD •	Decedent 10b. County CHARI	LES	10c. G	ity, Town or Lo	ocation WALDORF					10d. Inside City Limits 1 ☐ Yes 2 🔏 No						
al Dire	10e. Street and Nur 5545 W	nber OODRID(GE DRIV	Έ		10f. Zip Code 206	0f. Zip Code 10g. Citizen of What Countries 20601 U.S.A.							ountry?			
To Be Completed by Funeral Director	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 💥 Married	Armed F	2 No ive No	l	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes ※□ No Specify: Specify: WHIT:							etc.				
mpletec	Elementary/Seco	15. Decedent's cify only highest only highest only highest only highest (0-12)	grade completed)	1-4or 5+)	(Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) NER / OPERATOR A PLUS P											
o Be Co	12 17. Father's Name JACKI	(First, Middle, La E JAY (Γ) OWN	18. Mother's Name (First, Middle, Maiden Surname) KATHERINE GLORIA THOMAS											
To Be Complete	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD E. SHARPE, SRSPOUSE 5545 WOODRIDGE DR. WALDORF, MD. 206												1				
		position ☐ Cremation 3 5 ☐ Other (Spe		01.11	cemetery, cre	osition (Name of ematory or other pla HILL CEM	ce)		Date 28-09	1		Oity or To					
	21. Signature of Fu	meral Service Lic	censee MO	0479	F	22. Name and Addr RAYMOND LA PLATA	FUNE MD.	RAL 20	SERVI 646	CE,	P.A.	•					
	23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List on (Final	a.	caused the dea each line.	ath. Do not er	nter the mode of dy	ng, such as	cardiac	or respiratory				Approximate Interval Betwe Onset and De				
Examiner	Sequentially list co if any, leading to in cause Enter Undo Cause (Disease or that initiated events resulting in death)	injury	с	o (or as a conse													

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician end attending physician end for use as the burial-translt

cate has been signed by the atte page 2 should be detached for a

To the Funerel Director: After this certific completely filled in by the funeral director,

Be Completed by Physician/Medical

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 Unknow

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

3 🗌 Ectopic pregnancy 5 ☐ Other (specify)

28c. Injury at Work?

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

and manner stated

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No

3 V obably 4 ☐ Unknown

5 MResidence 6 ☐ Other (Specify)

Other: 4 \(\sum \) Nursing Home 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Months)

Registrar's Signaty

State Registrar

O

09-08951 Lizette Sierra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 38536

		- For State	,	Certificate	of D	eath				Reg.	No.		
Physiciar	1/	1. Decedent's Name (First, Middle,Last)				-				Date of Death	ay Year	3.	Time of Death
ledical Examin	er	Lizette		Sier						Month D November 1			1100 hrs
	ľ	4a. Facility Name (if not institution, give	street and number)			City, Town			Death		4c. County of I Prince Ge		
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday		f Under 1		If Under	24Hrs.	8. Date of Birth(MM/DD/YYYY) !	9. Birthp	lace (State or
Director		100-58-6785	M 2xF 45				Days	Hours	Min	July 10) F	Coun	yew York
any any	<u> </u>	Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	cation							1	0d. Inside City Limits
<u> </u>	,	Yaryland Prince Geor		Ft. Wa		aton							Yes 2 XX No
Maryland 28a-f show d at once.	턍	10e. Street and Number	ge 3	I C. WCL		Of. Zip Cod	de			10g	. Citizen of What	t Country	y?
th the Maryland 23a or 28a-f sho	Director	4511 LuJean Lane				207	44				USA		
ath with tems 23	Funeral	11. Mantal Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces?			ecedent of specify Co				cify Yes or No- can, etc.)	14. Race - White,		n Indian, Black,
ter de		3 Widowed 4 XXDivorced	1 Yes 2XX	No 1	χΥe	es 2	No	specify: F	Puert	to Ricar	Specify: H	lispa	anic
urs af	함	15. Decedent's Education (Specify only	or Dates:	ed) 16a. Dece	dent's	Usual Occ	upatio	n (Give ki	ind of wo	rk done 1	l6b. Kind of Busi		
72 ho	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		•	of working			ise retired	a)	17-11	· l-	
yo3(Straight of the straight of th												
Customer Service 12 Customer Service 17. Father's Name (First, Middle, Last) Ralph Vargas Ralph Vargas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)										Burgos			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street Route Number, City or									20744	+		
re, rand land land land land land land land l	Ī	20a. Method of Disposition 1 Burial 2 XX Cremation 3	Pomoual from State	20b. Place of Dis			of ceme	· L			20c. Location - 0	City or To	own, State
Pages bent of ant: I	1	4 Donation 5 Other Specify:	Tremoval from State	Kalas Cre					11/3	30/2009	Edgewat	er, N	Maryland
Baltimore, permit. Pages 1 an Department of Hea Important: If it injury or other trees	21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral 6160 Oxon Hill Road Oxon Hill, Maryland											1. Hon 207	ne P.A.
Physician	+	23ac Part I. Enter the disease, or compli	cations that caused the	death. Do not en									Approximate Interval
/Medical		failure. List only one cause on each mmediate Cause (Final disease a.	ch line. Narcotic (1	norphine) i	ntoxi	icai	tion					Between Onset and Death
xaminer	- 1		Due to (or as a conseque										
	١	Sequentially list conditions, b_		of):	_							-	
	in e	cause. Enter Underlying Cause	Oue to (or as a conseque	ence or):									
cuted and transit	Examiner		Due to (or as a conseque	ence of):									
e exe	/Medical	X UNPENDED 23a,27,28a-f,perm,E g898 12/10/09 TT											
760, Teate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	of pregnancy							23d. Date of o		ay Year
Box 68: c death certiff the attending ed for use as t	Physician	past 12 months?	1 Live birth Pregnant at time		_	death r (Specify)		Ectopic	pregnan	СУ	Month	D	ay rea
BOy e death the atte	ysi	1 Yes 2 No 9 V Unknown	9 Unknown) 0010	()							
s, P.O. Be ires that the de signed by the	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in	the und	derlying ca	use gi	ven in Pa	rt I.	71			ne cause of death?
duires	fed									24a. Was a			opsy findings available
cords law requi	Completed									autops perforr		rior to co eath?	empletion of cause of
Vital Rec ysician: The his certificate I director, page	팅								10: 1	1 Y Yes 2	2 No 1	✓ Yes	8 2 No
ician:	8		ospital: 1 Inpatient	2 ER/Outpa	tient		1/	of Death (Other ₄	<u>` </u>		Residence 6	Other:	Scene
n of Viding Physical After this funeral dir	음	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)					y at Work			ow injury occurre		
on C ath.	Ë	1 Natural 5 Pending	Ed 11/18		n • n () am 1	Y	es ₂ X	No	unk			
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should to	fica	2 Accident Investigation 3 Suicide 6 X Could not be	28e. Place of Injury	- At home, farm,	street,	factory, of	ffice bu	uilding, etc	c.	28f. Location (S	treet and Number	er or Rur	al Route Number, City an Lane
Divisior pital or Attendous after death ours after death teral Director: filled in by the	Certification:	4 Homicide determined		nd at re	sid	lence			l:	Fort Wa	shingtor	n, M	D Barre
Division of Vital Records, P.O. Box 68 within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certif and the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) 2 Certifying Physici	an: To the best of my kr On the basis of examin	nowledge, death ation and/or inve	occurre stigatio	ed at the tir on, in my op	ne, da pinion,	te and pla death oc	ace, and occurred at	due to the cause the time, date a	e(s) and manner and place, and d	as state ue to the	d. e cause(s)
To Your	Mec	29b. Signature and title of certifier	and manner stated.					number			29d. Date signe		
		all him	11 1				D.C.N	Л.E.			November	19, 20	09
		30. Name and address of person who	completed cause of dear	h (Item 23a)									
		Melissa Brassell, MD As	ssistant Medical E	xaminer 1	11 Pe	enn Stre	et, B	altimore	e, MD 2	21201			
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	11.	00 (1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 38537 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 9 30 P M ISE 23,2009 Jovembur /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner 4 BALTIMORE WAShington MEDICAL CENTER BUY ne Armde If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F 93 Days Hours 217-40-0508 Director CZECHOSLOVAKIA -12-16 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience intent to a cellified at Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 806 OAKWOOD 21061 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) VOZENILEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAN STEPANEK, IR. TASADENAMD. 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-25-09 ODENTON, MD. Name and Address of Facility DaughERTY FUNEAR HOME MOD942 2601 MOUNTAIN RO PASADE Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed and Due to (or as a consequence of): attending physician a for use as the burial-68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery law requires that the death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown à s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate Vital 2 XNo 1 ☐ Yes 2 5 1 □Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1-patient 2 ER/Outpatient 3 DOA this o 27. Manner of Death After t 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural (Month, Day, 5 Pending investigation n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu 2 Accident 1 ☐ Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8006

Please Type or Print in Black Ingelible IIII. 2.102.

amend #39be Performance Department of Health and Mental Hygiene 2009 38538 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month II **Physician** Claude G. Sitler 2009 1:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carrol1 Westminster city 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 06-2,7-1937 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 187-30-2247 Yrs PA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD Carroll Westminster city 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 1234 Washington Rd 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 white 1 ☐Yes 2K No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 Is marked other than "other traumatic event, the Was Elementary/Secondary (0-12) College (1-4or 5+) assistant to congressman politics 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie E. Oakes Ned R. Sitler, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City of Town State, Zip Code)
3991 Little John Dr. Wrightsville, PA 173 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troones. Joel E. Sitler - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cremation Direct Service 11-24-2009 York, PA 17401 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burg Funeral Home, Inc. 21. Signature of Funeral Service Licenses 134 W. Broadway Red Lion, PA 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** evere near disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-transit and or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 100 1 ☐ Yes 2 ☐ Mo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a Hospital Till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 52035 2009 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHACKO trong 291 クロンロ Stores 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 2 2009 Registrar

State of Maryland / Department of Health and Mental Hygien 2009 38539 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician EVELYN A. SAYLOR 18 2009 1:00 P M Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cecil Laurelwood Nursing Home Elkton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 2/9/1918 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F 91 Yrs. Director 212-28-9412 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at PA Chester West Grove 1 ☐ Yes 2 ☐ Mo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 12 Oak Lane USA 19390 Items 23a death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or lest may injury or other traumatic event, the Medical Examples once. 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Tes 2 No ģ 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Production Line Worker Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Burmel William Cavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith M. Torres/Daughter 12 Oak Lane, West Grove, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/21/09 Bryansville Cem. Delta, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Coneral Service Lice see 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA17314 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Alheroscleratio Immediate Cause (Final disease or condition resulting in death) Onset and Death Heart Discouse **Physician** /Medical Due to (or as a conse Examiner Hypertension Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit fell Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Prelmonary DISause Chronic Obstructive 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20023322 11.18.2009. Jachder S MD. 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 A, E tugg St, E-Cheton MD21921. SACHDEN MD 32. Registrar Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene? $\bigcap Q$

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	deat deat	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 13. V		ic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No- 14. Race	- American Indian,
98	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner mast be routthed at	V Fu	1 ☐ Never Married 2X Married 1X Yes 2 ☐ N	lo	Yes 2 X No <i>Spe</i>			White, etc.
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e,	es 1 a of He of He litem		20a. Method of Disposition		sition (Name of natory or other place)	11/19/2009		ity or Town, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maricel Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22	. Name and Address of F	Facility urdock Funer nd St., Oakl	al Home. F	2. A.
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NIA.	the Hospital or thin 24 hours after the Funeral Dire mpletely filled in the		one) 2 Medical Examiner: On the basis of and manner state	examination and/or inv	estigation, in my opinion	, death occurred at the tim	ne, date and place, an	d due to the cause(s)
		Medical Cert	Medical Examiner: On the basis of	examination and/or inv	occurred at the time, da estigation, in my opinion 29c. License number	, death occurred at the tim	he cause(s) and man ne, date and place, an 29d. Date signed (d due to the cause(s)
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INIG	To the Hospi within 24 hou To the Funer completely fil	Medical	29b. Signature and title of certifier	examination and/or inved. ath (Item 23a) (Type, F 1 N. 4th St r's Signature	29c. License numb	ber	29d. Date signed (d due to the cause(s)

Box 68760. P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

rgiene Reg. No. 2009 38541 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 9, 2009 **Physician** Joseph James Towney, Sr. 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9828 Squirrel Place Charles La Plata 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days August 8, 1937 Washington, DC Months Hours 1 M 2□ F 72 577-50-1668 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shove event, the Movical Examines must be multiped at 1 □Yes 2 No Director La Plata Maryland Charles 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 9828 Squirrel Place USA 20646 permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must. once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas E. Towney Alice Grantham ပ 19a. Informant's Name/Relationship (Type. Print)
Linda Schroat/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9829 Squirrel Place, La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Queen of Peace Cem. 14, 2009 Helen, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signalu 30195 Three Notch Rd., Charlotte Hall, MD 20622 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** en disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only or examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Dea 28b. Time of 28d. Describe how injury occurred Natural
2 Accident
3 Suicide 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BB54 170 31. Date filed (Month, Day, Year) Registrar's Signature State 132009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Gilbert Tebeleff 2009 7:15 A M November 8, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday Months Days Hours Min. 05/05/1922 87 Washington, DC 577-22-8479 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Silver Spring Montgomery 10e, Street and Number 10g. Citizen of What Country? 3200 North Leisure World Blvd. United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. was Decedent Ever in U.s Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Retail Shoe Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Tebeleff Rose Halper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Tebeleff 8916 Cold Spring Road Potomac, MD 20854 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdn. 11/10/2009 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Mem. Chapels, Inc 21. Signature of Funeral Service Licensee Jamie Arthurs M01163 1170 Rockville Pike Rockville,MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Cardiac Arrest Sequentially list conditions, Due to or as cause. Enter Underlying Cause (Disease or injury reguence that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2∏ No

/Medical Examiner

Physician

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Examiner

Funeral

Director

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Item 27 is marked other than "natur other traumatic event, Ins Medical

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is in any injury or other traum once.

12 should be filed with and Mental Hygier 7 is marked other the

72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

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Physician

Examiner burial-tra physician the burial attending for use as been signed by the should be detached page 2

law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

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Certification: To

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ospital or Attending Physician: hours after death.

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu

State Registrar

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

D60826

11/08/2009

hama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kshama Garg 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Mont)

32. Registrar's Signature sensur

ORIGINAL

DHMH 17 Rev 1/2001

Trickay, Elizabeth J Baltimore, Maryland 21215-003

	4 1	" 0.	For State D,Registrar	au mour			aryland /		artment <i>tificat</i> e			and M			20	09	3854	. 1
	-		1. Decedent's Name	(First, Middle			oha	Cer	lilicate	: 01 1	eaur		2. Date of De		o		3. Time of Death	_
	Physicia Medic	al	ELIZABET										NOV CM b	$\overline{}$	201		1043	۷Ī
	Examin	er	4a. Facility Name (if						4b. City, T	Town, or		of Death		40	County of Talb	,		
	Funeral Director		5. Social Security Nu 137–30–9	umber	6. Sex 1 ☐ M 2 ☐	7. Ag	e (In yrs. last bii	rthday) Yrs.	If Under			24 Hrs. Min.	8. Date of Bir 11/14/		9	. Birthp	ace (State or Foreig	n
	nd how at	'n	Usual Residence of 10a. State	Decedent 10b. County			10c. City, Tov	vn or Lo	cation							11	Od. Inside City Limit	s
	Maryla 28a-f s otified	Director	MD	TALBO'	r		EASTON	Ī:									1 X Yes 2 1	
	th the		10e. Street and Num		ATTE				10f. Zip		-			_	itizen of Wha	at Coun	ry?	
	ems 2	Funeral	106 WEST	BAKLE	12. Was D		Ever in U.S.	13. \	216 Was Decede	ent of His	spanic Ori	gin? (Spe	ecify Yes or No-	U.S	• A •	America	an Indian,	_
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marri		ried 1 🗌 Y	l Forces? 'es 2 X Give r Dates.	No	-1	f Yes, specif				Rican, etc.)		Black, N Specify:WI			
15-(72 hou n "natı fledica	Completed		cify only highe	nt's Education st grade comple			(Give i	dent's Usual kind of work O NOT use i	done di		t of worki	ing	16b. l	Kind of Busin	ness Ind	ustry	
212	within giene.		Elementary/Second 12	onday (0-12)	Colleg	e (1-4 or 5			CIVE S	,	ETARY	7		AER	OSPACE	S EN	GINEERING	j
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (,								e (First, Middle,	Maiden	Surname)			
aryla	nould b nd Mei s mark umatic	ľ	19a. Informant's Na				19	b. Mailir	na Address	(Street a			BRADY Al Route Number	r. Citv o	r Town. State	e. Zip C	ode)	
Ž,	nd 2 sk ealth a m 27 is ier trai		JANE B. H.		RIEND				•	•			MD, 2		,	-, -,-		
Baltimore,	Page 1 aument of Hament of Hament If iter		20a. Method of Disp 1 ■ Burial 2 I 4 ■ Donation	☐ Cremation	3 ☐ Removal fi	rom State	cemet	ery, cren	sition (Name natory or oth METER	her place	· •		8 ^{te} 2009 ∤2009		ORD, N	-		
Balt	permit. Depart Import any inj		21. Signature of Fur					FF	Name and	Addres H	s of Facilit	BEIN	& NEW	MAN	FUNERA	AL B	OME, P.A.	
	Physician/		23a. Part 1. Enter t	t failure. List o	complications the	nat cause	d the death. Do		or the mode	HARI of dying	RISON J, such as	cardiac o	FAST(on,	MD, 21	1 601	Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	n	a. Due	to (or as	a consequence	510 of):	edin	>						-		_
	Examiner	er	Sequentially list co	nditions,	b. 44	1/10/	12003	M	ien								_	_
	rted d ansit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	rlying iinjury	H	U.D	er ten	SI ~										
	execuian and	EX.	that initiated events resulting in death) i		C. Due	tò (onas	a consequence	of):	1									
760	cate be physic the bu	edical			d											\pm		_
. Box 687	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 t 1 Yes 2 2 9 Unknown	nonths? No	1	ive Birth	of pregnancy 2 Fetal dea at time of death		Ectopic pr Other (spe		4				23d. Date of Month		ry Day Year	
P.O.	that the		Part II. Other signif		ons contributing	to death t	out not resulting	j in the u	underlying ca	ause giv	en in Part	1.	23e. Did t	obacco	use contribu	ite to th	e cause of death?	
rds,	een sig	ted	Diabe	this 1	neut	VS	_						1 🗆	Yes 2	No 3	☐ Prob	ably 4 Unknow	vn
Division of Vital Records,	The law recate has bo	Completed by							· · · · · · · · · · · · · · · · · · ·				24a. Was auto perfo	psy ormed?	pric dea	or to cor th?	sy findings availabl npletion of cause o 2 No	e
/ital	sician: certifi	To Be	25. Was case referre examiner?	ed to medical	Hospital:	احجاد	ient 2 ER/0	N 4 4 !		Othe	r·		k only one)		a □ au _ a			-
of/	ng Phy ter this neral d	te: T	27. Manner of Death		28a. D	ate of injudent	ıry 28b.	Time of injury		Bc. Injury work	at		ome 5 Resi 28d. Describe I			Specity)		_
ion	ttendir death. tor: Af the fu	Certificate:	2 Accident	Investi	gation				M	1 🔲	Yes 2	No	T					_
) į Viš	al or A s after I Direct		4 Homicide	determ	ined 286. Pi	uilding, et	ury - At home, t c. (Specify)	arm, str	eet, ractory,	опісе			28f. Location (City or Tov			ir Hurai	Houte Number,	
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach	Medical	(Check 2	☐ Medical E	Physician: To the xaminer: On the Nurse Praction	basis of e	examination and	or inves	tigation, in m	ny opinio	n, death o	ccurred at	t the time, date a	and plac	e, and due to	the cau	se(s) and manner sta	ate
	LZZ With Sommon		29b. Signature and	title of certifier	San	1	m		29c.	License ØP	number	76%)	29d. Da	ate signed (A	Nonth, E	Day, Year)	
_	7		30. Name and address	20	who completed	cause of c	leath (Item 23a)	part y		011	M	P	219	50	uth	19ta	on Stree	+
	Sta Registr		31. Date filed (Mont	h, Day, Year) NOV 0 9		2. Registr	ar's Signature	4	and									_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar	Certificate of		Reg.	No. 200	3854
ian	Decedent's Name (First, Middle, Last) MICHAEL MATTHEW	IS THOMPSON	2	2. Date of Death Month	^D , 2009	3. Time of Death
ical ner	4a. Facility Name (If not institution, give street and number)		n, or Location of Death	Too work to too	4c. County of Deat	
	Frederick Memorial Hospit	al Fred	lerick		Frederi	ck
	219 - 96-6994 ¹ X M 2□ F	42 Yrs. If Under 1 Yes Months Da	vs Hours Min.	B. Date of Birth (Month, Day, Yes	ea <i>r) C</i> o	hplace (State or Foreign untry) yland
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
ţ	Maryland Frederick	Cascade	!			1 □Yes 2¶□No
Director	10e. Street and Number	10f. Zip Coo	e	10g.	. Citizen of What Co	untry?
	25415 Cascade Rd.	217				ates
Funeral	11. Marital Status 12. Was Decedent 6 Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ N	Ever in U.S. 13. Was Decedent If Yes, specify C	of Hispanic Origin? (Spec Luban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
þ	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🚮 N f Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2X	No Specify:		Specify: B1	ack
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation ne during most of working tired)	7 16	b. Kind of Business/	Industry
Som	Elementary/Secondary (0-12) College (1-4or 5	Warehouse S			lanufactur	ing
Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name	First, Middle, Mai	iden Surname)	
မ	Charles Robert Thomp		Jennifer			
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Str				Zip Code)
	Ruth Thompson / Wife 20a. Method of Disposition	20b. Place of Disposition (Name or cemetery, crematory or other	ade Rd./ Cas		c. Location - City or	Town, State
	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Stauffer Cremator		2009 Fr	ederick,	MD
	21. Signature of Funeral Service Licensee	22. Name and Ad			neral Hom	
	Tresmond Teler	1621 Opos	ssumtown Pik	e/ Frede	rick, MD	21702
	resulting in death)	ne.	1	respiratory arrest	,	Approximate Interval Between Opset and Death
	Due to (or as	a consequence of):	scular 8	· sana		Years
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):				
Examiner	that initiated events	a consequence of):				
	Due to (or as	a consequence ory.				
edic	d					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3 Ectopic pregn			23d. Date of de Month	livery Day Year
by Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the underlying cause	given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
				1 □ Yes	2 No 3 P	robably 4 Unknown
Completed				24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Be C	25. Was case referred to medical examiner?		26. Place of Death	1 □Yes 2 (Check only one)	\$110 TO 10	2 0110
卢	1 ☐ Yes 2 No Hospital: 1 Inpatie	sit 2 Levoupatient 3 DOA		e 5 Residenc	ce 6 ☐ Other (Spe	cify)
	27. Manner of Death 1 Natural 28a. Date of Inju (Month, Da) investigation	y, Year) Injury \	njury at 28 Vork? 1 □ Yes 2 □ No	3d. Describe how	injury occurred	
Certification:	2 Deviside 6 Decould not be	ury - At home, farm, street, factory, offic. (Specify)	ce 28	3f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	29a. Certifier (Check only one) 12 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or investigation, in r	e time, date and place, a ny opinion, death occurre	nd due to the cau d at the time, date	se(s) and manner a e and place, and due	s stated. e to the cause(s)
		29c Lic	ense number	29d	. Date signed (Mont	h, Day, Year)
Medical (29b. Signature and title of certifier		10 -11		1, 11/20	
	> MTolino MD	^	1051610		11/6/09	
	30. Name and address of person who completed cause of d	^		k. Marvl	7 -1)1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 38546 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 1:08PM 6, November Lawrence James Treat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2□ F July 7, 1942 New Jersey 67 139-32-0387 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Edgewater Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21037 1740 Havre de Grace Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give 1960-71 Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Quality Control Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Treat Constance Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cherami Wescott-Treat / Wife 1740 Havre de Grace Dr., Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-10-2009 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral 2973 Solomons Island Road Edgewater, MD. 21037 Approximate Interval Between Onset and Death 23a. a 7. Enter the isease, or complications that caused s ock, or he is tailure. List only one cause on each line immediate Calise (Final disease in ondition a. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease ondition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If was outcome of pregnancy 23d Date of delivery

Physician /Medical **Examiner**

permit. Pages 1 Department of H Important: If Itel any Injury or ott

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

ges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hyglene. It flem S72 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Moral and the staumatic event, it is Moral and it is must be realised at

12 should be fi th and Mental H

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Examine physician and the burial-transi Physician/Medical attending ph s been signed by the should be detached Medical Certification: To Be Completed by ours after death. eral Director; After this certific filled in by the funeral director,

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregn 4 ☐ Pregnant at time of death 5 ☐ Other (specify 9 ☐ Unknown		Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause	givon	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknow
25. Was case referred to medical		26. Place of Death (Check only	one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Res	sidence 6 Other (Specify)
27. Manner of Death Natural 5 Pending	(Month, Ďay, Year) Injury M	njury at Work? 1 □Yes 2 □No	how injury occurred
3 ☐ Suicide 6 ☐ Could no determin		ce 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
29a. Certifier (Check only one) 2 Medical E	Physiclan: To the best of my knowledge, death occurred at the caminer: On the basis of examination and/or investigation, in and manner stated.	te time, date and place, and due to the my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and title of certifier	// 29c. Lic	cense number	29d. Date signed (Month, Day, Year)

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State

e Funeral

To the I within 2

32. Pegistrar's Signature 31. Date filed (Month, Day, Year) NOV 09 2009

29b. Signature and title of certifie

ress of person wi

MO

mpleted cause of death (Item 23a) (Tigge, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Veres, Sr. 2009 November 0150 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 6, 1936 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Hours 73 Director 292-32-4910 Jan. Ohio Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 X Yes 2 ☐ No Bel Air 10f. Zip Code 10g. Citizen of What Country? Funeral 700 West Bel Air Avenue, Apt. 202 21014 12. Was Decedent Ever in U.S. Armed Forces?

11 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🛛 No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Aberdeen Proving Ground permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Instructor Aberdeen, Maryland Eight Years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steve Veres Anna Casper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 West Aztec Street, Aberdeen, Maryland Deborah A. Simpers (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/21/09 4 Donation 5 Other (Specify) R.A.Ferris & Co., Inc. Pennsylvánia 21. Sign Tre of Funeral Service Licenses Lee And Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death End ska Physician Cholangio Carcinoma disease or condition resulting in death) Medical Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequer nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 24 No
9 ☐ Unknown Month Dav Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page performed No. 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 4 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 060768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) who completed cause of death (Item 23a) (Type, Print)
To bhacker, 500 Upper Chexpeake Dr., 4HIVA Nuhammad 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 1 9 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year MABEL BOWYER PAIN VANZUYLEN /Medical Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hospice Lake 11comico at the alisbury If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day Year) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖸 F Months Days Hours Min 578-07-3043 94 Director Washington D.C. Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 Sumac Circle 21804 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ∐Yes 2 X No Black, White, etc. 1 Never Married 2 Married 21215-0036 1 □Yes 2 🛣 No If Yes, Give Year or Dates \$ Specify: White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, it as once. 12 Secretary Federal Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bowyer Pain Emily Mabel Tunks ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Adrian VanZuvlen / son 1014 Sumac Circle, Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/13/2009 Cedar Hill Cemetery Suitland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 107 Vine Street Holloway Funeral Home, P.A. Pocomoke City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes □ No
9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes → □ No 24a Was an autopsy performed? Yes 2010 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 5 Other (Specify) HCSP/CA 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of leath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAN Hustin nth, Day, Year) NOV 12 31. Date filed (Month, Day, State 2009 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Helen Eileen Vogel 2009 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Hours 87 **Director** 578-54-3084 24,1922 Canada March Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland St. Mary's Mechanicsville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 39022 Golden Beach Road 20659 Canada items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2XXMarried ŏ þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No "natural", 3 Widowed 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi f Health and Mental item 27 is marked မ William Robert McDonald Mair Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15450 Homeland Drive, Hughesville, MD 20637 Robert Douglas Vogel/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Maryland Veterans Cem. 2009 4 Donation 5 Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facilit Brinsfield-Echols Funeral HOme, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ nenmon Medical resulting in death) Due to (or as a consequence of) Examiner Low enca Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical law requires that the death certificate be He/en こパペの V ヴェ/ Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year 1 Yes 2 Unknown completed filled in by the funeral director, page 2 should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by seuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 2 or Attending Physician: The After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1-Natural 5 Pending injury 24 hours after death Funeral Director; A 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature an title of certifie 29d. Date signed (Month, Day, Year) 60888 M.D 09 05 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) Rakhí Krishnan, M.D. Leonardtown, MD 20650

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signatu

9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 7:20 AM **Physician** VonStein November 19, 200 Deloris /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Lions Center for Rehabilitation Cumberland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day,) Nov 4, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Year) 1931 **Funeral** Days Hours Months 1 □ M 2 □ F MD 220-26-9513 78 Director Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Express must be notified at Cumberland 1 □ Yes 2 □ No MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 14721 Howard Street by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ Mo Baltimore, Maryland 21215-0036 Specify: If Yes, Give white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 should be filed w h and Mental Hygiel 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eunice Pearl (Ruby) Northcraft Russell L. Northcraft Pages 1 and 2 should မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 12903 Henrietta Drive Cumberland MD 19a. Informant's Name/Relationship (Type. Print) MD 21502 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Vonda Mathews daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/23/2009 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Carpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part T. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only order ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 421 **Physician** disease or condition resulting in death) elaslote /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy The law requires that the death Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown q | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 ☐ Yes certificate 1 ∏ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check only one)

29b. Signature and title of certifier

filed (Month, Day, Y

DEC O

30. Name and address of person who completes

0

cause of death (Item 23a) (Type, Print)

32. Registraris

00033280

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00 AM 14. 2009 November Janice Diane Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hughesville

| Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birtuplace Country)

August 16, 1955 | Maryland 4104 Beverly Drive Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 X F 54 Director 216-70-8900 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Martical Evantricement be notified at once. 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 1 ☐Yes 2X No Funeral Director Maryland Charles Hughesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20637 USA 14104 Beverly Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12th. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna May Graves George Arthur Robey ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4104 Beverly Dr., Hughesville, MD. 20637

Be of Disposition (Name of Date 20c. Location - City or Town, State Larry Wilson/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. CemeteryNov. 24, 2009Cheltenham, MD. 22. Name and Address of Facility 21. Signature of Funeral Service License Huntt Funeral Home MONGO 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or compidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lyp. Immediate Cause (Final **Physician** uno disease or condition resulting in death) /Medical Due to (or as a conse (cence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause; Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Artifice 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) 076 31. Date filed (Month, Day, Year State 18 Registrar

Physician

23a. Part 1. Enter the disease shock, or heart fallure. Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter processing Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant con-

disease or condition resulting in death)

IF FEMALE

/Medical Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

State Registrar

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Yenneral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit

ice Dicense	22. Name and Address of Facility Hun	tt Funeral Home	
Well-morrage	3035 Old Washington	Rd. Waldorf, MD.	20601
, or compileations that caused the death. Do not list only one cause on each line.	enter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death
_a 520515			2 days
Due to (Ar as a consequence of):			
1 neutropenio	a		1 week
Due to (or as a cons + uence of):			
c. Chemother in Due to (or as a consequence of):	ipy treatment		2 months
d. Small cell	lung Cancer		2 months
	<i>J</i>		
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	elivery Day Year
ditions contributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacco use contribute t	to the cause of death?

transplant secondary to ESRD 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 █ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

22 South Greene St., 9W, Baltimore, MD 21201

AU4176435A18283

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janell Alden Sherr M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

BBL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Shirley Williams Walbert 11:45 /Medical give street and number) 4a. Facility Name (If not institution. City, Town, or Location of Death 4c. County of Death Examiner NMHS Braddock (lampus umberland (Sate or Foreign If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) December 30, 1926 5. Social Security Number 6. Sex 7. Age (In vis. last birthdav) Funeral Days Hours 1 □ M 2 X F Maryland 213-24-5416 Director 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner count be notified at 1 ☐ Yes 2 No Directo Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 22118 Seldom Seen Road 21539 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 □ Yes 2 No Specify: Specify: ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. em 27 Is marked other than ther traumatic event, I've M Elementary/Secondary (0-12) College (1-4or 5+) Lab Tech Paper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Williams Stella Howell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau Jay Walbert - Son 19738 National Highway N.W., Frostburg, Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date November 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. View Cemetery Moscow Mills, Maryland 23, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A ε. 8 East Main Street Lonaconing, MD 21539 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC NEUROENDOCRINE TUMOUR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Exami ettending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∏ Yes 2 🗷 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 Accident 2 🗆 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier

State Registrar

Е

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

20 MD 904 Seton Drive, Cumberland, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

amanmo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_1	Hegistrar	Cer	rtificate of I	Death		leg. No.	
	ysicia	_	1. Decedent's Name <i>(First, Middle, Last)</i> Jane M. Wells				2. Date of Dear	th Day Yes r 8, 2009	NA NA
	/ledic amin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Novembe	4c. County of D	
Fun		. !	Casey House 6. Sex 7. Age 085-22-8345 1 □ M 2√ F 7. Age	(In yrs. last birthday) 81 Yrs.	Rockvi1 If Under 1 Year Months Days	1e If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07/08/1		ery Birthplace (State or Foreign Country) ew York
faryland show	कर्त बार		Usual Residence of Decedent 10a. State 10b. County MD Montgomery	10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the N	st be notif	Funeral Director	10e. Street and Number 18602 Reliant Drive		10f. Zip Code 20879			10g. Citizen of What United St	•
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show	Examiner.mu		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ No. If Yes, Give X Year or Dates:	n	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 1 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: W	merican Indian, /hite, etc. hite
Z I Z I 3-0036 I within 72 hours aft giene. r than "natural", or	Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give		ation during most of work d)	ing	16b. Kind of Busine	
na L	vent, th	Be Co	17. Father's Name (First, Middle, Last)	пошен	liakei			Maiden Surname)	е
ryland hould be file ad Mental Hy marked oth	matic e	<u>P</u> .	Francis P. Moynehan 19a. Informant's Name/Relationship (Type. Print)	10h Mailir	on Address (Street	Elizabet		ngleton er, City or Town, Stai	te Zin Code)
, IVICAL and 2 st ealth and 27 Is n	er trau		Barbara D'Agostino / Daught	er 18602	2 Reliant	Dr. Gait		g, MD 208	
Daltimore, Waryland permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 Is marked of	ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Vale Cren	natorium	11/14	/2009	20c. Location - City Schenecta	dy, NY
Dall permit Depart Import	any In		21. Signature of Funeral Service Licensee				-	ler's Son hington,	
Physic /Med Exami	ian ical		resulting in death) Due to (or as a	the death. Do not ent e. y Fibrosis consequence of):		ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
tificate be executed by physician and	the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events c.	consequence of):					
I TECOTOS, P.O. BOX 06/00, The law requires that the death certificate be executed ate has been signed by the attending physician and	ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	У		23d. Date of Month	delivery Day Year
rdS, Privires that n signed b	ld be deta		Part II. Other significant conditions contributing to death bu Small Bowel Obstruction, H			en in Part I.			te to the cause of death? Probably 4 🙀 Unknown
al Hecords 1: The law requires if cate has been sign	r, page 2 shou	Completed by	Aortic Stenosis				24a. Was a autop perfor 1 □Yes	prior rmed? deat 2 No 1	e autopsy findings available to completion of cause of h? Yes 2 □ No
DIVISION OF VITAL MED TO THE HOSPITAL OF Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	by the funeral directo	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injur	(Year) Injury	f 28c. Injur Wor M 1 □	4 Li Nursing no	ome 5 ☐ Resid 28d. Describe h	dence 6 Other (Specify Hospice IPI or Rural Route Number,
ospital or hours after ineral Dire	ily filled in		4 Homicide building, etc. 29a. Certifier (Check only 2 Medical Examiner: On the basis of	f my knowledge, deat	h occurred at the ti	me, date and place	and due to the	cause(s) and manne	er as stated.
To the Hi within 24 To the Fi	сотріет	Medical	29b. Signature and title of certifier	ted.	29c. Licens			29d. Date signed (M	fonth, Day, Year)
	Sta	e	30. Name and address of person who completed cause of de Jocelyn Kouatchou MD 6100 M 31. Date filed (Month, Day, Year) 32. Registra	uncaster N	Mill Road	Rockvill	e, MD 2	0855	
Re	gistra		NOV 4 A AAAA	un D. sa	parked				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year James Leonard Wheeler, Sr. 7:00 /Medical November 11, 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 24313 Hurry Road Chaptico St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 11 M 2□ F Months Days Hours Director 217-36-8838 April 10, 1926 Maryland Usual Residence of Decedent r 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland St. Mary's Director Chaptico 1 □Yes 2 N No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Vedical Examination ust ber 23a 24313 Hurry Road 20621 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after on the should be filed within 72 hours after on the should be should 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: 2 1 ☐Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) 12 Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph မ Latham Wheeler Alice Maude Russell Just 1 and 2 shc.
Just 1 and 2 shc.
Just 1 lem 27 is many injury or other:
Once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24313 Hurry Road, Chaptico, MD 20621 Agnes Cecelia Wheeler / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State November 14, Sacred Heart Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Bushwood, Maryland 2009 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21 Sign ture of Funeral Service/License Vichaels P.O. Box 270, Leonardtown, MD 20650 Jardener 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Dause (Final SEPSIS **Physician** disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed physician als the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Year 5 ☐ Other (specify) Day Division of Vital Records, P.O. ☐Yes 2☐No detached 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE DULMONAMY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has pade autopsy certificate performed 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🗷 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Hospital: 1 Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Bank inD D0014168 No 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28103 THREE Notch Rd MECHANICS VIlle, Md 20659 ROBERT J. BAUKRIMD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 12 2009 James S. park

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Pauline Odell Weaver 3:15 2009 November /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13016 Spickler Road Washington Clear Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, Jan. 8, **Funeral** Months Days Hours 1 □ M 2187 F 579-03-8967 90 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, Inv Medical Examination of califord at Director 1 ☐ Yes 2 ☑ No Maryland Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5808 Jefferson Pike 21703 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: è Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail permit. Pages 1 and 2 should be filk Department of Health and Mental Himportant: If Item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Roy West Anna Archer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5808 Jefferson Pike, Frederick, MD 21703 Kemper L. Weaver / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Nov. 10. 4 Donation 5 Dother (Specify) 2009 Resthaven Crematory Frederick, Maryland 21. Signature of Fu Resthaven Funeral Services, Skkot Cody P.A. Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1 Enter the dispase, or co sho for heart failure. List on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Imme Te Cause (Inal disease or condition resulting in death) **Physician** Alzhei Demen meis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No 4 Pregnant at time of death Month Day Year 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 performe certificate 1 ☐ Yes 2 No 1 □ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier M.D. 0058181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street # 306 Hagerstown

Registrar DHMH 17 Rev 1/2001

State

324 E. Antietam

32. Registrar's Signature

PEPRAH

31. Date filed (Month, Day, Year)

NOV 10

09-09066 Lauren Witte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

auren Witte		State of Maryland / Depa				Mental F	łygiene		
τ.	F	I- For State Registrar 1. Decedent's Name (First, Middle,Last)	tificate of	Death			2. Date of Dea	eg. No. 2 (109 3855
Physician Medical Examin	-	Lauren Amber Witte				_	Month Novembe	r 21, 2009 Year	1654 hrs
	ı	4a. Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	4	b. City, To Salisb		cation of Dea	th	4c. County of D Wicomico	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la 216–04–0689 26	st birthday)	If Under		If Under 24H Hours Mi	2	Fo	. Birthplace (State or preign
Director	-	210-04-0689 1 M 2XF 26 Usual Residence of Decedent	Yrs.				07/02	2/1983	Maryland
v any	İ	10a. State 10b. County 10c. City,	Town or Location						10d. Inside City Limits
Maryland 28a-f show any d.at once.	إي	Maryland Wicomico S 10e. Street and Number	alisbur	Y 10f. Zip (Code			log. Citizen of What	1 Yes 2 X No
the Mar a or 28; iffed at	Director	6846 Lois Ave.			1804]	USA	Southly.
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 2 Armed Forces?				anic Origin? (: Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.
ufter dea	by Fur	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Date:	1	Yes 2	X No	specify:		Specify: \	white
hours a		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent during mo			n (Give kind o OO NOT use re		16b. Kind of Busin	ess/Industry
5-0036 led within 72 Tygiene. other than '	Completed	12 2	n/a					n/a	
21215-0036 ould be filed within 7 I Mental Hygiens is marked other than is event, the Medica	် မြ	17. Father's Name (First, Middle, Last) Walter F. Witte			18		ne (First, Middle, Maxwell	Maiden Surname)	
212 ould be I Menta s mark		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address	(Street			mber, City or Town, S	State, Zip Code)
- p # # #		Walter Witte/father 20a. Method of Disposition 20b. F	6846				isbury,	MD 21804 20c. Location - Ci	ty or Town State
- ← - • •		1 Burial 2 X Cremation 3 Removal from State	crematory or oth	er place)			1/24/09	Salisbu	
altin mit. P. partme portan ury or	1	4 Donation 5 Other Specify: Sci 21. Signature of Funeral Service Lie heep							
	-	25a. Part I. Enter the disease, or complications that caused the death.	Do not enter th	Ol Sr	OW F	ill Rd	., Salis	sbury, MD	1 Association 21804 Approximate Interval
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Seizure diso			-,		, , , , ,	,	Between Onset and Death
kaminer		or condition resulting in death) Due to (or as a consequence of							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ð):						
si.	Examiner	(Disease or injury triat initiated events resulting in death). Last Due to (or as a consequence of	5:						
e be executed ysician and burial - transit	edical	d. AMENDED 0.2 0.7	- MT	- 000	10/	20/00 5	D.M.		
760, icate be physici the buri	/Med	X UNPENDED AMENDED 23a, 27, IF FEMALE: 23c. If yes, outcome of pregration to the live birth	nancy			_		23d. Date of de	
O.O. Box 6876C that the death certificate are by the attending physical detached for use as the b	Physician/M	past 12 months? 4 Pregnant at time of de		al death ner (Spec	ify)	Ectopic preg	nancy	Month	Day Year
D. Bc		1 Yes 2 No 9 ✓ Unknown g Unknown Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying	cause giv	ven in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
ires that the signed by	d by						1 Ye	es 2 🗸 No 3	Probably 4 Unknown
of Vital Records, ng Physician: The law requiring. The this certificate has been simeral director, page 2 should the	Completed						24a. Was	psy pric	re autopsy findings available or to completion of cause of ath?
tal Rec		25. Was case referred to medical		2	6 Place	of Death (Chec	1 ✔ Yes		Yes 2 No
Vital F ysician: this certifi director,	e Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient			ther:	sing Home 5	Residence 6	Other:
Ision of Vital Records, P.O. Box Attending Physician: The law requires that the death reath. After this certificate has been signed by the atterby the funeral director, page 2 should be detached for up the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director and t	on:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	njury 2		at Work?	28d. Describe	how injury occurred	
Division tal or Attendir rs after death al Director: A led in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, stree	et, factory,			28f. Location or Town,		or Rural Route Number, City
		4 Homicide determined (Specify)							
Divi	Medical	Check only one) 2 W Medical Examiner: On the basis of examination and manner stated.	je, death occuri nd/or investigat	red at the ion, in my	opinion,	e and place, a death occurre	nd due to the cau d at the time, date	use(s) and manner as e and place, and due	to the cause(s)
To with	₹	29b. Signature and title of certifier		29c	. License				(Month, Day, Year)
		30. Name and address of person who completed cause of death (Item	23a)		O.C.N	I.E.		November 22	<u> </u>
OCME		Mary G. Ripple MD. Deputy Chief Medical Exar		Penn	Street,	Baltimore,	MD 21201		
Sta		31. Date filed (Morath, Day, Year) 2009 32. Registrar's Signatu	ref. Sa	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dav Month Welsh Leberah 3:25 PM /Medical 20 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center BALTIMENZ University of 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Aug 2, 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F_X Months Days , 1956 Hours Min. 213-72-2689 53 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Allegany Cumberland Director 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 King Street Funeral 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ 💑 If Yes, Give Year or Dates δ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 is marked other the any injury or other traumatic event, Its Ones. housekeeping Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Amos Collins, Sr. lanes Mae (Sulser) Collins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 100 King Street Cumberland MD 19a. Informant's Name/Relationship (Type. Print)
Thomas Welsh husband MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 11/25/2009 4 ☐ Donation 5 ☐ Øther (Specify) Cumberland MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fall Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on course on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or constion resulting in death) **Physician** poric Kespiratory ~10 hrs /Medical (or as a consequence f) Examiner erebral Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cerebral and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) the 9 Unknowi signed by 1 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 No 24 hours after death Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKOYE

31. Date filed (Month, Day, Year,

N.

32. Registrar's Signature

11-20-2009

Baltimure, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year O 9 Month 1243 M **Physician** Donald Raymond Woods /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner allegany WMHS-Braddock Campus umberland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min. Director 233-78-4944 March 27,1947 Keyser, WV Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Practical Exeminar must be notified at once. 1 XYes 2 ☐ No **Funeral Director** WV Mineral Keyser 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Pages 1 and 2 should be filed within 72 hours after death with 35 Carroll Avenue 26726 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗶 No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Elementary/Secondary (0-12) College (1-4or 5+) Fabrication 12 Sheet Metal Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Theodore Woods Lola Irene Leatherman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene S. Woods/ Wife P.O. Box 752 Keyser, WV <u> 26726</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Duling Cemetery Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Smith Funeral Home 85 S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INVASIVE LUNG INFECTION CACTINOMYCES? Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ACUTE RENAL physician and s the burial-tran that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 19 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After propered in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24

To the F

complete 29d. Date signed (Month, Day, Year) CARDIOTHORAGIL 29c. License number 29b. Signature anotitle & certifie D66694 Musi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SUBRATO

31. Date filed (Month, Day, Year)

DEB, MD

32. Redistrar's Signature

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902 SETON DRIVE, CUMBERLAND, MD 21502

			For State	State of Maryla		artment <i>rtificate</i>			nd Me		giene _{Reg. No} . 2 (1119	38560
Pł	hysicia	an	1. Decedent's Name (First, Middle, Last)					<u>-,</u>	2	2. Date of De Month	-	Year O	3. Time of Death 3:30A M
-	/Medic		Harold Stephen 4a. Facility Name (If not institution, give s			4b. City, To	own, or	Location of	1	and	4c. Count	by of Death	
	neral ector		5. Social Security Number 6. Sex 412–50–8918	M 2□ F 7. Age (In yi	s. last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 24 Hours	Hrs. 8	B. Date of Bir (Month, Da Feb. 9	th ly, Year) ,1919	9. Birthp	lace (State or Foreign
		_	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation		<u> </u>				1	0d. Inside City Limits 1 ☐ Yes 2 ¥ No
the Ma	r 28a-f	Funeral Director	WV Mineral 10e. Street and Number		Keys	10f. Zip (Code				10g. Citizen of	What Cour	
ith with	23a o	ralD	Rt. 4, Box 219				6726					ISA	
BaitImore, Maryland ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al", or items	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW		Was Decede If Yes, specif	fy Cuba	ispanic Origi in, Mexican, Specify:	n? (Spec Puerto R	ify Yes or No ican, etc.)		ace - Americ ack, White, ify:	
// 15-0 /ithin 72 ho ne.	han "natur e Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	k done d e retired	during most o	of working	9	16b. Kind of I		
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Mal nd 2 sh alth and	27 Is n r traun		19a. Informant's Name/Relationship (Ty) Edith V. Walters/			ng Address				ser. W			
artimore, rmit. Pages 1 a partment of Hea	int: If Item iry or othe		20a. Method of Disposition 1	20b emoval from State	Place of Disp cemetery, cre	osition (Nam matory or oth	e of her plac	ce)	_	v. 24 009	20c. Location	- City or To	
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Phys /Me	ician dical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the de e cause on each line. Due to (or as a cons	Myo	carcl	/ 0	ng, such as c	lardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
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BOX 6	attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□ Ectopic pr □ Other (spe		÷у				Date of delive	ery Day Year
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o 🖁 🖁	After this of funeral directions	tion: To	1 Yes 2 No	28a. Date of Injury (Month, Day, Year	28b. Time		8c. Injui Wor	ry at	2		how injury occ		ify)
DIVISION al or Attending s after death.	I Director: ed in by the	Certification: To	3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s ecify)	treet, factory,	, office		2	8f. Location City or To	(Street and Nui wn, State)	mber or Rui	al Route Number,
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₩'			30. Name and address of person who co	mpleted cause of death (tem 23a) (Type	JAU	ve.	Cun	ibe	erka	nd	Me	2009 A 21502
F	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Barch	1						

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/Medic Examin		4a. Facility Name (If not						Location of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c. Cou	nty of Death	1
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t	Certification: To	2 Accident	☐ Pending investigation	28a. Date of Inju (Month, Da	ury 2	8b. Time of Injury	28c. Injur Worl	v at	28d. Describe			,
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		30. Name and address o	f person who con	pleted cause of	death (Item 2	(Type, F	101	71 00	-+ AFF:-	2 Pd	lotala	icas Mn
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Avenb Connie Jean Wiles Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Months Hours 1 M 2 X Days Director 219-34-5732 Marvland August Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 330 Locust St. 21740 U.S.A. or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o မ Η. Longnecker other traumatic Barbara В. Hartle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra William F. Wiles / Husband 330 Locust_St. Hagerstown Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Hav<u>en Cemetery</u> 11/25/2009 | Hagerstown, Maryland 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an has autonsy prior to completion of cause of death? certificate ade. 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 masy vance

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year) DEC 0 2 20

09-08954 Jerry Weese Please Type or Printin Black-Indelible-Ink, Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

rry Weese		- For State of Maryland / Department of Health and Mema	Reg. N	200	9 3856
Physici edical Exami	an/	legistrar 1. Decedent's Name (First, Middle,Last) JERRY WEESE	2. Date of Death Month Da November 18		3. Time of Death 1250 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of I 5525 Johnson Avenue Bethesda		4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 1 Year If Under 1 Y	24Hrs. 8. Date of Birth (Min. OCT. 10,	M/DD/YYYY) 9. Birti Cou 1962 MAR	nplace (State or Foreign ntry) Y L AND
w any		Usual Residence of Decedent			10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	WV BERKELEY HEUGESVILLE 10e. Street and Number 39 LUCILLE LANE 10f. Zip Code 25427	10g.	Citizen of What Coun	**
ath with the items 23a o ast be notifi	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygers, in the file of the title more is marked other than "natural", or items 23a or 28a-f she inter other traumatic event, the Medical Examiner must be notified at once	ক্র	3 Widowed 4 Divorced if Yes, Give Year or Dates: 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT u		b. Kind of Business/li	·
5-0036 led within 72 hours Hygiene. tother than "natur	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION 1. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, Maid	RESIDEN	TIAL
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be		OAN JACKSON per or Rural Route Numbe	r, City or Town, State	, Zip Code)
t, MD 2121 and 2 should be fi lealth and Mental tem 27 is marked traumatic event,	욘	TAMMY J. WEESE/SPOUSE 39 LUCILLE LANE, H 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery,	EDGESVILLE,		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If tiem 27 is marked other in injury or other traumatic event, the Med		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 X Other Specify NTOMBMENT	NOVEMBER 23, 2009	MARTINSB	
Baltii permit. J Departm Importa		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	MARTINSBURG, V		BUX 821,
Physician /Medical xaminer	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caffailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ratae of respiratory arross	, 6,100,11, 6,11,100,11	Between Onset and Death
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O, e be exect vsician an burial - tr	Medical	UNPENDED AMENDED		23d. Date of deliver	<u> </u>
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in whe funeral circcon, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	pregnancy		Day Yea r
i, P.O. Bo ires that the de signed by the 1 be detached f	<u></u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Hypertensive Atherosclerotic Cardiovascular Disease		2 No 3 Pro	the cause of death? bably 4 Unknown
cords, I s law requires e has been sig e 2 should be	nplete	Type tendre of the control of the co	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
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Divisior tal or Attend rs after death al Director: led in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Single Family 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family	c. 28f. Location (Str	reet and Number of R Ite 0525 UONI Le Hedgesville LWV	ural Route Number, City 1501 AVE. Bethesda, M
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	ace, and due to the cause(curred at the time, date ar	(s) and manner as stand place, and due to t	nted. he cause(s)
To with	Med	29b. Signature and title of certifier O.C.M.E.		29d. Date signed (Me November 19, 2	
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Regi	State	31. Date filed (Month, Day, Year) 30. Begistrar's Signature			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lois Elaine Wolfinger 9:15 P.M November 12, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20754 Millers Church Rd. Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 11, 1938 5. Social Security Number Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 71 Hours 1 M 2 J 219-34-5492 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Evantins: must be notified at 1 □Yes 2 □No Director Md. Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 21742 U.S.A 20754 Millers Church Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2☐No Specify. 5 White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Correction Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event sones. Be Ruth J. Wallick ပ္ Jacob P. Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20754 Millers Church Rd. Hagerstown, Md. 21742 Russell A, Wolfinger Jr. Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 16, Green Hill Cemetery Waynesboro, Pa. 1 2009 22, Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lucera) **Physician** 12 month Amyotrushic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Š s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 □ Yes 2 ►€0 page 2 1 ☐ Yes 2 □ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 SAResidence 6 ☐ Other (Specify) 1 Tes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) spital or Attending Plours after death.

neral Director: After the filled in by the funera 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division of Vital Records, To the Hospital within 24 hours a To the Funeral C

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) terson 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

	1	State of Maryland / Depa	rtment of Health and Me rificate of Death	ental Hygier Reg. 1	211119	38565
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
Physiciar /Medica		Hammond Eugene Weber, Sr.		Nov. 17	2009	1:40 A
Examine	r 4	ta. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl Baltimo	
		2121 Gibson Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	White Hall If Under 1 Year If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
Funeral Director		218-32-7185 1MM 2□F 73 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Pay, Ye May 14, 19	36 Mar	yland
To To	- 1	Usual Residence of Decedent				
arylar show		10a. State 10b. County 10c. City, Town or Loc				10d. Inside City Limits 1 ☐ Yes 2 No
Ba-f	Directo		te Hall 101. Zip Code	100	Citizen of What Co	
with 1	<u>.</u>	10e. Street and Number 2121 Gibson Road	21161	log.	U.S.A.	unity:
death me 23	runerai		Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - Ame	
5-0036 72 hours after death with the Maryland "neturel", or iteme 23a or 28a-f show pical Examinar must be notitized at	Dy ru	1 □ Never Married 21X Married 1 □ Yes 21X No	Yes, specify Cuban, Mexican, Puerto H □ Yes 2 <mark>X</mark> No <i>Specify:</i>	ican, etc.)	Black, White	hite
215-0036 ithin 72 hours after a number of the second secon	Led Led	15. Decedent's Education 16a. Deced	ent's Usual Occupation	16b	. Kind of Business/	
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	5 -		ervisor		anitation	Dept.
tal Hill Hill Hill Hill Hill Hill Hill Hi	e i	17. Father's Name (<i>First, Middle, Last</i>) Charles H. Weber	18. Mother's Name	openhave		
arylar should be nd Menta marked amatic ev	<u> </u>		Address (Street and Number or Rural			Tip Code)
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ire, Maryla s 1 and 2 should if Haalth and Mar item 27 is marks other traumatic	2	20h Place of Disposition	ition (Name of Da		Location - City or	
		1 XBurial 2 Cremation 3 Removal from State *4 Donation 5 Other (Specify) West 110 Methodist	erty United Nov. Cemetery 200	9 W	nite Hall	, MD
Baltimore, permit. Pagas 1 ar Dapartmant of Haa Important: if item any injury or other		21. Signature of Edneral Service Licensee 22.	Name and Address of Facility J. Second St., No.			TO THE PERSON NAMED AND POST OF THE PERSON NA
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/Medical		resulting in death) a. Due to (or as a consequence of):				10901.4
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		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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daath cartific a attanding p		in the past 12 months? 4 Pregnent at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year
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	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the un HIERTENSION, DEMENTIA	derlying cause given in Part I.	23e. Did tobacc	/	othe cause of death?
w raquire	lete			24a. Was an	24b. Were au	itopsy findings available completion of cause of
m E 0 5	E			autopsy performed 1 ☐ Yes 2 ☐	? death?	2 No
VITAL F.	0	25. Was case referred to medical	26. Place of Death		140	
- S S S	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		e 5 Residence		cify)
On O		27. Mann of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how in	njury occurred	
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그 무슨 그 그		4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, ractory, office	City or Town, St		nar riodio ridinbor,
To the Hospital or within 24 hours after To the Funeral Dir complataly filled in		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death				
he Ho in 24 I he Fu plataly	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invented and manner stated.	estigation, in my opinion, death occurre			
To t to t com	Σ	29b. Signature and title of certifier	29c. License number 053095	29d.	Date signed (Monti	h, Day, Year) 17, 2009
10		30. Name and address of person who completed cause of death (Item 23a) (Type, F		#710	Tinoniu	m, MO 21093
State	9	31. Date filed (Month, Day, Year) 109 32. Registrar's Signature				
Registra	r	DEC O & was been by				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ackson Edward /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner General Hospital Howard Count Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Min. 1**X** M 2□ F Director none Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 5370 Smooth Meadow Way or items 23a 21044 U.S.A Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. rmed Forces? 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' filed within Elementary/Secondary (0-12) College (1-4or 5+) infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ unknown Nicole Flaine Barton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jocelyn Phillips permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 12511 Blue Ponds Terr, Beltsville, MD 20705 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 02, 2009 Clarksville, Maryland Columbia Memorial Park Signature of Funeral S wice I censes 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Soler the disease or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Drematurite disease or condition resulting in death) /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) burial-trar resulting in death) Last Due to (or as a consequence of) physician the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy for Month Ye ar Day 5 Other (specify) the 9 Unknow signed by t i be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate | perform 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No 1XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760, \langle

Baltimore, Maryland 21215-0036

within 24 hours after death To the Funeral Director: filled in by

Medical

29a. Certifier

(Check only one) 29b. Signature and tit

31. Date filed (Month, Day,

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle Last) 2. Date of Death Physician/ Month 22:18 Medical Penhe Location of Death Examiner 4c. County of Death HIMOVE s. last birthday) Yrs. If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Director 28a-f show 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director Himore 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) College (1-4 or 5+) nday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) ٥ 20b. Place of Disposition (Name of gemetery, crematory or other place) 1 Burial 2 □ □ □ Other (S 🛕 Burial 2 🗌 Cremation 3 🗌 Removal from State 21. Signature of Euro 32. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic disease or condition resulting in death) Obstructive Medical Due to (or as a consequence of) Examiner Stage IV Non Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 2 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 မှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No M Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, Division of Vital

Box 68760

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of eqrtifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month. Day, Year)

November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#17perFH, G898, 12/3/09, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Dec. Edith L. Boller 9:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Keswick Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan Year 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🗗 F 94 Hours Merwand 213-05-7522 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Nottingham Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 7912 Hilltop Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo 2 If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4or 5+) Housewife Homemaker injury or other traumatic event, 17. Father's Name (ETI Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Elewerth Lescalleet Clara Lee Paine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 7912 Hilltop Ave. Nottingham, MD. 21236 Marjorie B. Stitz - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cem. Dec. 5, 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Pikesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eune al Service Licensee 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. mn 11605 Reisterstown Rd. Owings Mills, MD. Gen) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final hysician an disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, pe IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an tate has page 2 s autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending to hours after death. 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Bolto and Zizox

MA

670

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
DEC 0 3 2009

6 house

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 29^{ay} Bret William Barrett 11:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Months 02-12-1958 216-76-2049 MaryTand **Director** 51 ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Middle River 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Barbie Court 21220 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify. Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Regional IT Manager Veolia Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William R. Barrett Joan Thomas Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda Barrett - Wife 10 Barbie Court Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 12/02/2009 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signatur of Fineral Service Licensee 5305 Partord Road 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. El ter or derning Cause (Disease or iinjury Due to (or as a consequence of) Exam **To the Hospital or Attending Physician**: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): physician ar s the burial-to resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 1 Yes 2 g ned by the a e detached f Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt I be d by 1 Yes 2 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number) determined Medical 1 🐪 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number Massan Nassar D0053617 1 2009 December 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Housan Nasser Unien Memorial Mospiel 201 East

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, 2009 Month **Physician** 10:20 A M L. November Elfriede Barnes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10269 Gainsborough Road Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 3, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Min. 1 □ M 2 🗓 F Months Hours 097-34-7416 1933 Director 76 Germany Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State d other than "natural", or items 23a or 28a-f show event, the liedical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 10269 Gainsborough Road 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White δ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer Television Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Wilhelm Tegtmeier Ida Minna Rider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald S. Hanauer 20 Highland Farms Drive, Bedford, New Hampshire 03110 Department of Health Important; If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1. Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Ind Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 permit. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Robert A. Pumphrey Funeral Home/Be 7557 Wisconsin Avenue, Bethesda, Ma Shock, of heart failure. List only one cause on each line. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatocellular Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending philosophilos use IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Ethanol Abuse, Tobacco Abuse 1X Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? Yes 2 X No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? or Attending 5 Pending investigation 1 X Natural To the Hospital or Attendia within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0055522 November 27, 2009

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year)

03

2009

1500 Forest Glen Road, Silver Spring, Maryland 20910 Robert H. Gerard, M.D. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Frank Robert Baxter 2009 11:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5325 Westbard Avenue #326 Bethesda Montgomery 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Year) 50 1 X M 2 | F Months Davs Hours Min. Washington, D.C. 579-62-8225 Director 59 June Usual Residence of Decedent 28a-f shov 10b. County 10a. State other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 5325 Westbard Avenue #326 United States permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked Attack. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Vietnam 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Boating Company 0wner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Wilson Baxter Norma Lee Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 S. Kent Street, Winchester, Virginia 22601 William John Baxter/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Termation 3 Removal from State November 2009 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase. Inc Bethesda, Maryland 20814 Pumphrey Funeral Home/ . 7557Wisconsin Avenue 21. Signature of Funeral Service Licenses M01498 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Pulmonary Hypertension Sequentially list conditions, Divi to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Esophageal Cancer that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year 2 No a | Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital မှ

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, certificate has irector, page 2 ral director. after death.

Director: Aft
in by the fur

Other: 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🏲 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

within 24 hor To the Fune completed fi Tx State

24 hours

Certificate:

Medical

29a. Certifier

only one 29b. Signati

Harvey S. Washington,

DEC 03

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD14478

29c. License number

50 Irving Street, N.W., Washington, D.C. 20422

29d. Date signed (Month, Day, Year)

November 27, 2009

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jingwu Cao 28, 2009 1:35 Α November 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Suburban Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🖾 F 218-57-5160 78 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 K No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 4521 East-West Highway, #1211 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Year or Dates Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5 <u>Technical Librarian</u> Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) Wenlan Yu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5714 Wyngate Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 2. Montgomery Crematorium, Inc. 2009 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01548 Approximate Interval Between Onset and Death Complications of Aspiration Pneumonia Due to Complications of Mixed Drugs Intexication Due to (or as a consequence of): mo Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner** law raquires that the death certificate be executed attending physician and P.O. Box 68760, the 28 nis certificate has been signed by director, page 2 should be detach Division of Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: Director: After this in by the funeral di death. 24 hours a hin 2

Physician

Examiner

Funeral

Director

/Medical

Director

Funeral

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31. Date filed (Month, Day, Year)

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Eventian and united at anones. ģ 3 Widowed 4 □ Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ပ Wenbin Cao 19a. Informant's Name/Relationship (Type. Print) <u>Wen Xiao/Daughter</u> 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuoeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 25. Was case referred to medical examiner? Be 1⊠ Yes 2 □ No Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural Oct. 22, 2009 12:00-13:00 1 ☐ Yes 2 🙀 No 2 Accident Patient Ingested Medications 6 □ Could not be 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Route Number, City or Town, State) 4321 Last West Highway, determined 4 Homicide Home #1211, Bethesda, Maryland 20814 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO November 28, 2009 D67986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 8600 Georgetown Road, Bethesda, Maryland 20814

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Amend #19b Per FH g898 12/03/02 earth Cate of Death Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 826 A M MUSMOUR 2009 Anna Gross Cassidy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMONE
If Under 1 Year | If Under 24 Hrs. AGNES N/A 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Feb. 23 5. Social Security Number 7. Age (In yrs, last birthday, **Funeral** Year, Days Hours Min Scranton, PA Months 1 □ M 2 🛛 F 1924 85 Director 148-14-2114 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a, State 10h County 10c. City, Town or Location 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "hotical Examinar hear office at 1 ☐ Yes 21 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21228 600 Maiden Choice Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XX No Specify. Specify: White \$ 3 X Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Archdiocese of College (1-4or 5+) N/A Elementary/Secondary (0-12) Newark, 12 Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mathias Frederick Stemplinger Blanche Evelyn Heater ပ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) **Baltimore** 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Heatth and Important: If item 27 is n any Injury or other traun once. Pikesvill 21284 Father Joseph Gross, O.SS.T/Son P.O. Box 42056 MD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2009 Glen Burnie, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician O HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): attending physician that the death certificate be Physician/Medical the as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) the a P.0. 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed The certificate 1 □Yes 2 XNo 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XVo 1 → Apatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P23492 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENUE BALTIMONE 12 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09048 State of Maryland / Department of Health and Mental Hygiene Sandra Daugherty 1. For State Certificate of Death Rea. No Registrar 2 Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 21, 2009 0414 hrs **Medical Examiner** Sandra Lynn Daugherty 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** oreian 216-72-5792 Min. Months Days Hours Country) Maryland Director 03/15/1963 1 M 2 X F 46 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No 23a or 28a-f show notified at once. Baltimore death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 426 Kane Street 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married Yes White Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. If Yes, Give Year Specify: Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other than "r 9 Food/Restaurant Server/Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Carmelita Fazenbaker Billy Knee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t: If item 27 is nother traumatic 961 Redfield Rd., Apt.L, Bel Air, MD 21014 Carmelita Christy/Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/02/2009 Hanover, Maryland Ardent Cremation Services Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ardent Cremation Services MO1197 Hardest 7522 Connelley Drive Ste.N. Hanover 23a. Part I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute combined drug (methadone, amitryptyline and Approximate Interva **Physician** Between Onset and Medical alprazolam) intoxication Methadone intoxication Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially liet conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed **23a,per ME g899 1/22/10 TT** 23a,27,28a-f,permE, G898 12 Physician/Medical physician a the burial -X UNPENDED /29/09 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 V No 3 Probably 4 Unknown σ. Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy The law performed' death? Yes Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Hospital: 1 examiner? Other₄ DOA Nursing Home 5 Residence 6 Other: Inpatient 2 FR/Outpatient 3 this 1 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification To the Hospital or Attendin within 24 hours after death. unk Natura! Yes 2X No Division Director: I in by the f Pending Fd 11/21/09 Fd 3:30 am Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) $426\,$ Kane St BAltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be found at residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of cert November 22, 2009 O.C.M.E. DR alle 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

Registrar

Assistant Medical Examiner

a second

32. Registrar's Signature

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	f Marylar		artment of F			giene Reg. No.2 0	09	38576
	Physic		Decedent's Name (First, Middle, HELEN	Last)		DVC	SKIN		2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, g		mber)		4b. City, Town, o	r Location of Deat		4c. County		E
	Funeral Director		220-09-2608	. Sex 1 □ M 2 【X F	7. Age (In yrs.	last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1912	9. Birthp Cour	lace (State or Foreign RUSSIA
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD BÂLTI	MORE	1	ity, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 🂢 No
	th with the 23e or 28e	Funeral Director	10e. Street and Number 7920 SCOTTS LEV	EL ROAD			10f. Zip Code	1208		10g. Citizen of \	What Cour	utry? USA
9036	ours after death with the Maryla rrel', or Items 23e or 28e-f shor Examiner oust by mulficous	by	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 🖪 No If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ k, White,	etc.
Maryland 21215-0036	ed within 72 h ygjene. rer then "natu t, Ire Modical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0,12)	grade completed) College (1	-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor t) CLERK	rking	16b. Kind of Bu		
yland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumatic event, Ite Medical Examiner must be multified at once.	To Be	17. Father's Name (First, Middle, La FRIEDMAN DVOSKIN					18. Mother's Nar ESTHER	me (First, Middle,	Maiden Suman	DAVI	DOV
		1	19a. Informant's Name/Relationship MARIAN THOMPSON			7920	SCOTTS		AD, PIKE			Code) 21208
Baltimore,			20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		State	cemetery, cren	sition (Name of natory or other place ER CONG.	· 1	Date D3/2009 [20c. Location - BALTIMOR	-	
- Balt	permit. Departi Import any inj		21. Signature of Funeral Service Lic	enste	u		Name and Address					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that cally one cause on early a	aused the deaf ach line. Or as a consect	quence of):	er the mode of dyin Cescli idiu pal	g, such as cardiac Lei Lie	e or respiratory and	rest,	hing "	Approximate Interval Between Onset and Death ,
8760,	ate be executed thysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (c	or as a consequence or as a consequence	quence of): quence of):				<i>Jul</i>		
.O. Box 68760	The law requires that the death certificate has been signed by the attending planes 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	ıl death 3 □	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ry Day Year
\mathcal{N} Records, P.O.	quires that n signed b uld be deta	ed by Pl	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the ur	nderlying cause give	en in Part I.		bacco use contr es 2 □ No	ribute to th	e cause of death?
L al Reco		Completed							24a. Whas a autop: perfor 1 ☐ Yes	med2/	rior to cor leath?	osy findings available inpletion of cause of
OV 05/LUX	Phys this al dii	To Be	25. Was case referred by medical examiner? 1 Yes 2 No 27. Manner of Death 2 Natural 5 Pending	Hospital: 1 In In 28a. Date of (Month		ER/Outpatient	3 □ DOA Othe 28c. Injury Work	er: 4 Nursing H	ath (Check only or lome 5 ☐ Residence 28d. Describe h	ence 6 □Oth)
Helen () Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of		ome, farm, stre		Yes 2 □ No	28f. Location (S City or Tow		er or Rura	Route Number,
里	e Hospite 24 hours e Funerel etely filled	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the taminer: On the bas	sis of examina	wledge, death tion and/or inv	occurred at the timestigation, in my or	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place, a	nner as st	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c. License	.0 .0		9d. Date signed		
	2		30. Name and address of person who	o completed cause	of death (Item	1 23a) (Type, F	1)44	817	o are	DEC.	DM.	2007 .
0	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 3 2		gistrar's Signa	iture	w se	mella	e acce	Bel	nin	Pre'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25^{Day} Physician/ Month 2009 P M Luis Augusto Durand November 5:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Nov. 21, If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Days Hours Min. 1932 Director Yrs Nov. Venezuela None Usual Residence of Decedent 28a-f shov 10h County the Maryland at 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No Maryland Montgomery Chevy Chase 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 3210 Farmington Drive 20815 Venezuela items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 9 2 1 Never Married 2 X Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Venezuelan Specify: White "natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Je filed with... **al Hygiene. **ar than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Officer Venezuela Navv traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, th and Mental h 2 Jose Augusto Briceano Carmen Luisa Durand I and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alinda Iman/Daughter 3210 Farmington Drive, Chevy Chase, Maryland 20815 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of Informatic If ite any injury or ot montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 27, 2009 Bethesda, Maryland Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. aion M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Metastatic Colon Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or imjury that initiated events resulting in death) Last and-trar Due to (or as a consequence of): burialphysician the burial Physician/Medical that the death certificate be Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician; The law requires 1 ☐ Yes 2 ី No 3 ☐ Probably 4 ☐ Unknown been signature Completed 24a. Was an 24b. Were autopsy findings available page 2 s has autopsy prior to completion of cause of death? performed? Yes 2 K No 1 Yes **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify this s after death.

I Director: After this id in by the funeral d 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident 2 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one

30.

29b. Signature and title of certifier

oseman nd address of person who

completed cause of de

32. Registrar's Signature

Iwunze M.D. 8600 01&

29c. License number

D0065720

Reorgetown Road, Bethesda, Maryland 20814

29d, Date signed (Month, Day, Year)

November 25, 2009

			Please	Type or Pri	nt in Black I	ndelible In	k. Ensure A	III Copies	S Are Legi	ble.		
		_	For State Registrar		aryland / Dep	rtificate of L	Death	, F	Reg. No.	09 38578		
	Physicia Medic		1. Decedent's Name (First, Middle, Las Ronald W:	illiam	Eis	enhardt		2. Date of Dea Month Decembe	Day	3. Time of Death 5:45 AM		
	Examin	4a. Facility Name (if not institution, give street and number) 6 Keen Mill Court					4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore		
	Funeral Director		5. Social Security Number 6. S 219-38-3601	⁹ X M 2 □ F 7. Ag	e (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day March 2		9. Birthplace (State or Foreign Country)		
	and show dat	ě	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryl 28a-f	Director	MD Baltin	nore	C	atonsvil	Le			1 ☐ Yes 2 No Oq. Citizen of What Country?		
	with the s 23a or	Funeral I	6 Keen Mill Cour	=		21228	3		0	S.A.		
036	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	, No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛂 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Black	- American Indian, , White, etc. White			
15-0	72 hour n "natu ledical	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occup kind of work done o O NOT use retired)	during most of work	ing	16b. Kind of Bus	iness Industry		
212	iled within 72 I Hygiene. other than '		Elementary/Seconday (0-12)	College (1-4 or 5	O+)	nt Superv			Medica	al Technology		
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) George William Eisenhardt 18. Mother's Name (First, Middle, Maiden Sumame) Edna Mary Maximook									
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once.		19a. Informant's Name/Relationship (7		MITE	ng Address (Street	and Number or Rura		; City or Town, Sta			
ore,	e 1 and t of Hea If item or other		20a. Method of Disposition 1		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date		City or Town, State		
ıltim	nit. Pag artment ortant: injury		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Licen		Meadowrid				Elkridg	ge, MD Glen Burnie, MD		
Ba	permi Depar Impor any ir	Ц	Delena	nulik	101479 s	ingleton	Funeral 8	Cremat	ion Serv			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each me. Immediate Cause (Final disease or condition								or respiratory arre	est,	Approximate Interval Between Onset and Death		
-) Medical Examiner		resulting in death)	Due to (or as	a consequence of):	<i>J</i> (J					
10	red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequence of):							
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3760	ificate big physas the l	Medic	IF FEMALE:	l.d		-						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _				23d. Date of delivery Month Day Year		
ls, P.O.	uires that the signed by ald be deta	ed by Pi	Part II. Other significant conditions of	Diabe	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did to		oute to the cause of death? 3 Probably 4 Unknown		
Division of Vital Records,	The law req ate has bee page 2 sho	Completed by	vos culon a	ccide	nt			24a. Was a autop perfor 1 Yes	sy pr med? de	ere autopsy findings available ior to completion of cause of eath?		
ital	sician: certifica rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	□ FD/0:	Oth	lace of Death (Chec	/	0 0 0 0 0	(0-1)		
n of V	nding Physith. :: After this e funeral di	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of inju (Month, Da	ient 2 ER/Outpatie ury 28b. Time o injury	f 28c. Injur work	y at		ence 6 Other			
Divisio	al or Atters after des la Director din by the	Certificate:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural Route Number,		
_	e Hospita 24 hours e Funera	Medical	(Check 2 Medical Exam	iner: On the basis of e	my knowledge, death examination and/or invest best of my knowledge,	stigation, in my opini	on, death occurred a	t the time, date ar	nd place, and due t	to the cause(s) and manner stated.		
	To the Comp		29b. Signature and title of pertifier	40		29c. Licens	e number		29d. Date signed	(Month, Day, Year)		
	8		30. Name and address of person who	completed cause of d	part A o d	Print)	Sw. 7 2 21	0 6 4	Security (10 mo 21775		
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	les of	WITE T)	~~	, , , , ,		
	,		MITCH C. TAGO	A A TREE	See State Charles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maureen Drake Eiker 2:00 AM Medical Nov 21, 2009 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Min. Director Yrs 062-34-4558 67 Oct 21, 1942 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2651 Ledgends Way 21042 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2/A No Specify. 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Walter Drake Elizabeth Noonan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl E. Eiker spouse 2651 Ledgends Way Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 21, 2009 Glen Burnie, MD Atlantic Crematory, LLC Sith ture . Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure List only one cause on each line Interval Between Immediate Cause (Final Physician/ Onset and Death Pancreatic disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day rthis certificate has been signed by the arral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after deatn.

To the Funeral Director: After the funeral on the funeral pipe for the function of the funeral pipe for the function of the function of the funeral pipe for the function of 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined **Medical** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar an

Marian

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Grant

Charles

N.

32, Registrar's Signature

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Towson

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Hovember 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MURTLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 ▼ F 88 016-12-3514 Yrs 5/19/1921 Director MA Usual Residence of Decedent with the Maryland 10a. State 2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show raumatic event, The Medical Eventory, ust by profiled at 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Director Harwood 1√2 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3675 Solomans Island Road 20776 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes **2√X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify <u>á</u> Specify: ¥XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event ORDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph P. Hanley Marquerite Rock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Donovan / Daughter 3178 Catrina Lane Annapolis Maryland 21403-4345 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Grove Cem. 12/1/2009 Medford, 4 ☐ Donation 5 ☐ Other (Specify) Doda, Jr², Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 of Funeral Service License ${f Victor}\ {f P}_ullet$ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** CORUNARY Lan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if they, reading to humodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of): physician and the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a o 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à BREASI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No The law 24a. Was an Jas autopsy page After this certificate I funeral director, page 1 □Yes 2 □No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🗷 No 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred HUL or Attending 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of dertific who completed cause of death (Item 23a) (Type Name and address of person Print) Mo N

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month C Year **Physician** 12:30am 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GUEN 5 U2~13 ANNE ルラけんろ If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 357-16-0043 1 □ M 2√2 F 88 Director 9/10/21 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Anne Arundel MD Glen Burnie 1 TYes 20 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 109 Waterfountain Way, Unit# 204 21060 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1∐Yes 2**XX**o Specify white þ Specify. 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) White Waitress 12 nd Mental Hygie marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil. h and Mental H. 7 is marked oth Be Charles Newman Pearl Coxပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informant's Name/Relationship (Type. Print) Cheryl Wright 109 Waterfountain Way, Unit# 204 Glen Burnie item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore National Cem Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ₺ Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Important: If any Injury or once. 12/4/2009 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Fundal Service Licenseo Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed the burial-tran resulting in death) Last physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) detached 1 ☐Yes 2 ☐ No o 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by sign be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 1 🗌 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1∏Yes 27-No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this completely filled in by the funeral 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Division 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner-stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

5/-

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HENRY FUNK, JR. Vear Medical 2009 0452AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRanklin HOSPITA Square sedale Baltimore 7. Age (In yrs. last birthday) 73 Yrs. **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 218-32-3577 1**X**□ M 2 □ F Months Davs Hours 2-14-19 Director MĂRYLAND Usual Residence of Decedent or 28a-f shov 10a. State 10b. County with the Maryland rral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE MD ROSEDALE 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7914 MONTROSE AVENUE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important If item 27 is marked other trainmy or other trainmy. 14. Race - American Indian, þ 1 Never Married 2 XMarried Black, White, etc. ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2x☐ No Specify: Completed 3 Widowed 4 Divorced WHITE Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DRAFTSMAN AAI Be . Father's Name (First, Middle, Last) HENRY 18. Mother's Name (First, Middle, Maiden Surname)
ANNA FUNK, SR. (BRAUN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY FUNK/WIFE 7914 MONTROSE AVENUE ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 12-4-09 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ERLTIPUSION disease or condition Medical resulting in death) Examiner HOLLD TREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No igned by the atte be detached for Day Year g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury hours after death. Accident Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 18025 am

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Ave. Baldy, MD 21237

0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia L. Foster November 27, 2009 11:59 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death

Carroll Transitions Health Care Sykesville If Under 1 Year If Under 24 Hrs. Age (/i 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 216-24-1025 1 ☐ M 2**X**(X) F Months Days Hours Min. March 30° 1929 Mary Tand **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 KXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 4141 Marx Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify White 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the M-dical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 7. Father's Name (First, Middle, Last) Harlan Phoebus 18. Mother's Name (First, Middle, Maiden Surname) Alberta Bucher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Simmons/Sister 4141 Marx Avenue Baltimore Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Parkwood Cemetery 12/1/09 Baltimore Maryland reopard J. Ruck Facility 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) em entia Onset and Death nd Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Hospital or Attending Physician; The law page 2 s autopsy performe death? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number
D43725
29d. Date signed (Month, Pay, Year)
1//30/49

Ruad Westminister MD 2115 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAR 1Q MALMOUD 19, Fid 4C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23e, 24a, 25, 26, 27 per dr., 8898, 12 W2709dhb Certificate of Death Reg, No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 14, 2009 **Physician** 9:02 AMM Kenneth J. Feifarek /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Rennaisance Gardens Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 17, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 € M 2 □ F 89 1919 388-14-6639 Wisconsin Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it will be inclined at 1 ☐ Yes 21 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 USA 3126 Gracefield Road #220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 72 hours after 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: ģ 3 Widowed 4 Divorced 43-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Je filed ww. College (1-4or 5+) Elementary/Secondary (0-12) financial CPA 12 d 2 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie 1. Christopherson Adolph C. Feifarek ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20904 3126 Gracefield Road #220 Silver Spring, MD permit. Pages 1 and 2 Department of Health Important: If item 27 1 any Injury or other tra once. Health a Ruth Feifarek/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) State and Address Faceboard 655 W. Baltimore Street 21. Signature of Funeral Service Sicen Wade Baltimore, MD 21201 Approximate Interval Between 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician renal insufficiency disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed atrial fibrillation burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending ph IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by to be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 diabetes mellitus 2 🗌 No 3 Probably 4 X Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate med? 24 No 1 ☐ Yes 1 ☐ Yes 2 \square No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending I hours atter death. 1 X Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

P.0. Records, Division of Vital

State Registrar 31. Date filed (Month, Day, Year) DEC O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

3110

29c. License number

D44156

Rd Silver Spring

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OAM 100 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** il MURRSITY UF BALTIMONE MARYLAND Messight If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Months | Days | Hours | Min. | Month Days 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F **219-28-** Usual Residence of Director 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a Funeral items ? 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Kkuck 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No ŏ Specify 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surnar 17. Father's Name (First, Middle, Last) Be ၀ arvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is in any injury or other traum once. 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State (Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service License 22 Name and Address of Facility (15a/47) Des 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NRA C EREBIRA 1 HUNRINAGE **Physician** Medical Due to (or as a consequence of): **Examiner** HY DEKTEW if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transi The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No Physiclan: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25/40 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Impatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ₩ Natural 5 Pending investigation 1 ∏Yes 2 □ No ours after death, neral Director: A filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 9 within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Ye

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

TZVSAUEN 32. Registrar's

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38586 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November Yea 17 18 PM Physician/ SHIRLEY GOLDBECK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2X F Months Days Hours Min. 8-30-1942 MARYLAND 214-38-0933 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location Director MD BALTIMORE ROSEDALE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 1208 BERKWOOD ROAD U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Was Deceden 2.5. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) CUSTOMER SERVICE BANK Be Father's Name (First, Middle, Last) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked othany injury or other traumatic event .18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA (STACKS) PELYAK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEDALE, MD KRISTA BLANKENSHIP/DAUGHTER 1208 BERKWOOD ROAD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State CATONSVILLE, 12-3-09 METRO CREMATORY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE 21237 ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEVERE PULMONARY HYPERTENSION disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): death certificate be executed physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 page 2 🗌 No 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 ☑ No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending within 24 hours after death.

To the Funeral Director. Aft completed filled in by the fur 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 30, 2009 RES-000

Registrar DHMH 17 Rev 7/2009

State

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

4940

EASTERN AVENUE BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 7:31 A.M **Physician** November 27, 2009 Virginia Gibson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Prince George's County Hospital Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Days 1 □ M 2 🗓 F 1914 Virginia Feb. 7, 95 719-01-1372 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show ed other then "natural", or items 23a or 28a-f shov event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director Prince George Mitchellville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 10450 Lottsford Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: þ 3XWidowed 4☐ Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is merked other then "na eny Injury or other traumatic event, It. Mode. College (1-4or 5+) Elementary/Secondary (0-12) Railroad Secretary 3+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thez Mae Robertson John Hurley Daughtrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8201 Southwater Court; Springfield, VA Laurie Gibson Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/5/2009 Sykesville, MD take View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fineral Service Licensee MD 21228 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC ARRHYTHMIA Immediate Cause (Final FATAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760% Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 🗌 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. CHEVERLY MS 20785 SATTARIAN 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

12/3/2009 amh Amend #20b Per FH G898 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 38588 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** O DEMBEK 23,2009 Sohn COCRRISON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ballmere (senotal Co7 4105pHEL MACULand If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) eurity Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 2 M 2 □ F -434 RYINIA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State d 2 should be filed within 72 hours after death with the Marylar Ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Extrodit of must be refilled at 1 ☑Yes 2 ☐ No Ballimore Director d 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USM 21202 taye Ho Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ Ño Specify: ð 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) elivenu DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UATTIE ပ 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5,5+2 6,17 permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traumonce. Lan 215 BALTO Md 21202 E e//2 BOVERCE RYGUIA 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Scrvice Licensee 22. Name and Address of Facility 21213 13ROKA Wice Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dacleois /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). rdicipscular disess Exami Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 2. No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Dea h 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

certificate be executed and Box 68760, & physician s the burial ding atten signed by the a P.O. Division of Vital Records, page 2 should been funeral director, After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

Baltimore, Maryland 21215-0036

(Check only one) and manner stated. 29b. Signature and title of certifier ofin Mulacan

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATURY NAFEM, 501 DUPHIN STREET BALTIMORE MD2/21)

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Pм 7009 AWIOS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HIMOTE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Unk 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 🕅 M 2 🗆 F 220-32-0342 79 6/10/1930 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Modest Examiner must be notified at 1 ☐ Yes 2 XNo Director Caroline MD Denton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5863 Laurel Grove Road 21629 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) Unk 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) oartment of Health a cortant: If Item 27 is injury or other trains 5863 Laurel Grove Road, Denton, MD 21629 Andy Harris/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or Anatomy Gifts Registry 12/2/2009 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licer see 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical death certificate the as attending IF FEMALE yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2X No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 inpatient Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year)

State Registrar Catherine

29b. Signature and title of certifier

Registrar's Signature 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

M.D

29c. License number

18179

reenest Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. 2 U [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 00AM HO 28, 2009 NOVEMBEY /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner altmore

1 Year | If Under 24 Hrs Home (In yrs. last birthday) 1129 8. Date of Birth (Month, Day, Year) May 30,1932 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F h T Yrs -30-1306 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director MD MOY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral lanorview 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2: If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No þ Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Commission) on Aging) Balto MD 1221 ton ON al vert or other 20c. Location - City or Town, State 20b. Place of Disposition cemetery, crematory Date 20a. Method of Disposition i ... 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. Cemeter 4 Donation 5 Other (Specify) rsdowne Signature of Funeral Service Licens 22 Name and Address of acilit Ho me 300 WID alle Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician roshate disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed 00 Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 4 Unknown 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy 2 1 No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 140 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital within 24 hours a To the Funeral I completely filled Hospital 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler 210 MD D31464 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 308 SHOA113 3 Hm1 821 N. GHTAN ST Smite BALT | MORE M1 2,20 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	to the Funeral Director: After this certificate has been signed by the attending physician and
DIVISION OF VITAL RECORDS, P.O. DOX 66/60	To the Hospital or Attending Phys within 24 hours after death.	to the Funeral Director: After this

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	For State Registrar	State of Maryla		artment of F tificate of D			eg. No. 2 N	00 30501	
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Physician/ Medical	4a. Facility Name (if not institution, ga				Location of Death	NOVEMB	SK 33 5	2009 10:51AM	
Examiner	CIVISTA MED		{	LA PI	ATA		4c. County of Death CHARLES		
Funeral Director			. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1/25/19		Birthplace (State or Foreign Country)	
2	Usual Residence of Decedent					1/25/13	710	TN	
aryland la-f sho ified at	10a. State 10b. County Hillsk	orough 10c. 0	City, Town or Lo		mpa			10d. Inside City Limits	
leath with the Maryland items 23a or 28a-f show er must be notified at. Funeral Director	10e. Street and Number 7502 S. Mortor	Street		10f. Zip Code	33616		10g. Citizen of WI USA		
ter dea nor iter miner	11. Marital Status 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ► No lf Yes, Give Year or Dates.	1	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		- American Indian, , White, etc. Black	
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Page 1 and ment of He tant: If iten fury or other	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State Recify)		natory or other place n Mem Pai	rk 12/5/	/2009	Tampa		
permit Depart Import any inj once.	21. Signature of Euneral Service Lice	enswictor P. Dox	da, Jr 32	Name and Addres	ss of Facility L. Stevens Fort Ave	Funera	al Home,	Tnc	
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Medical	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	quence of):	hear	+ D/S	ease		Onset and Death	
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cate be physiciles the but									
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu Certificate: To Be Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 For Fregnant at time of 9 Unknown	etal death 3	Ectopic pregnanc Other (specify)	уу		23d. Date Mont	e of delivery th Day Year	
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certific rector,	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital:	F = 10	Otho	ace of Death (Check				
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s. Medical Certificate: To Be Comp	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work			w injury occurred		
al or Attending P s after death. In Director: After the in by the funera Certificate:	3 Suicide 6 Could no 4 Homicide determine			eet, factory, office	2	28f. Location (St. City or Town		r or Rural Route Number,	
the Hospita iin 24 hours the Funeral ipleted filled	(Check 2 Medical Exa only one) 3 Certifying N	hysician: To the best of my kno miner: On the basis of examinat urse Practioner: To the best of	ion and/or invest	igation, in my opinio	on, death occurred at t	the time, date an	d place, and due t	to the cause(s) and manner stated	
To To To 1	29b. Signature and title of certifier Uuhiw	4. Tagour	·up	29c. License				(Month, Day, Year)	
6	30. Name and address of person whe	o completed cause of death (Ite	em 23a) (Type, F	rint) Nesap	pl lan	lata n	1,0 200	646	
State Registrar	Junia M. Ta 81. Date filed (Month, Day, Year) DEC 0 3 2009	32. Registrar's sign	natura as file						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 200938592 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Geraldine Elizabeth Huff 3:40 PM Nov 26, 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 80 Hillside Rd. Catonsville If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2 🗙 F Months Hours Director 212-26-6356 93 MD Mar 27, 1916 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No **Baltimore** Catonsville MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 80 Hillside Rd 21228 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify er than "natural", the Medical Exa Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental marked ပ Elijah Hawke Alice Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other from 9 80 Hillside Rd. Catonsville, MD 21228 Carter Huff Son 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Dec 01, 2009 Ellicott City, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery 22. Name and Address of Facility 21. Sionature of Funeral Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown 9 Unknown as been signed by the should be detach. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has performed Yes 2 this certificate 25. Was case referred to medical examiner? **Division of Vital** Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 **X**ONo 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director; After 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of centi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.Charles

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician WILLIAM BOOTH HEINEFIELD 200 De cember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ose Mone Samare Franklin Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. last birthday 8. Date of Birth (Month, Day, Year) 7. Age **Funeral** Months Min 213-01-5256 1**∑** M 2□ F 91 Yrs 3-19-1918 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Wolcal Examination to notified at 1 ☐ Yes 2 XNo ROSEDALE MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 U.S.A. 7913 ELMHURST AVENUE Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 XYes 2 No If Yes, Give Year or Date\$ 945 – 46 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify. Specify: WHITE Completed by ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 MARTIN MARIETTA MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (GRANT) WILLIAM Η. HEINEFIELD EDITH P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19971 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 18528 BIG BURN LANE REHOBETH BEACH, DE RONALD HEINEFIELD/SON Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 12-4-09 BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 ROSEDALE, MD 1211 CHESACO AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rani disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed to (or as a consequence of): aftending physician a for use as the burial-68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Hlnknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

111

State Registrar

DHMH 17 Rev 1/2001

Franklin Square Dr.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

amile

Year)

31. Date filed (Month, Day,

9000

32. Registrar's Signature

0

Baltimore

09-09177 Avten Icapren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician	1	1. Decedent's Name (First, Middle,Last)				2. Date of Dear Month November		3. Time of Death 1530 hrs
ledical Examine		Ayten Icgoren 4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
	Н	University Hospital		Baltimpre				
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. 231–92–4708 1 M 2X F 8	•	If Under 1 Ye Months Da				Birthplace (State or Foreign Country) Turkey
any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Locat	ion				10d. Inside City Limits
. §			olumbia					1 X Yes 2 No
daryland 28a-f show 1 at once.	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	Country?
h the N 3a or		7383 Swan Point Way		210			Turkey	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	unerai	11. Marital Status 1 Never Married 2 Married Armed Forces?	J.S. 13. Wa	as Decedent of H es, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Race - Ar White, et	merican Indian, Black, c.
fter de	-	1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year	1 🗆	Yes 2X N	o specify:		Specify:	Turkish
nours a	a b	15. Decedent's Education (Specify only highest grade completed)			ation (Give kind of vie. DO NOT use reti	16b. Kind of Busine	ess/Industry	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Merical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	Do	ctor			Health	Care
21215-0036 uld be filed within 7 Mental Hygiene. The work of the Merica The Wester of the Merica	5	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle,	Maiden Surname)	
2121; uld be fil Mental F marked c event,	8	Mehmet Kazim	10h Mailin	a Address (Ch	Necmi		k) mber, City or Town, S	trate Zin Code)
nore, MD 2121. sges I and 2 should be fill to of Health and Mental I it. If item 27 is marked other traumatic event,	2 [19a. Informant's Name/Relationship (Type, Print) Nese E. Icgoren, Daughter					ia. MD 210	1
를 크 뚫 토 루	- 1	20a. Method of Disposition 20b		sition (Name of c		Date	20c. Location - Cit	
MOFE Pages 1: nent of H ant: If it		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	ersin C	emetery		06/2009	Mersin,	Turkey
Baltimore, permit. Pages I an Department of He. Important: If ite injury or other tr	Ī	21. Signature of Funeral Service Licensee T. Harman		Name and Addre	т,		Funeral Se	ervices, Inc.
Physician		23a. Part I. Ententhe disease, or complications that caused the deaf failure. List only one cause on each line.	h. Do not enter	the mode of dyin	g, such as cardiac o	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
M_dical xaminer	1	Immediate Cause (Final disease a. Multiple Injuries	- 0:					Death
,	-	or condition resulting in death) Due to (or as a consequence Sequentially list conditions, b.	oi).					
	直	if any, leading to immediate ause. Enter Underlying Cause	of):					
E - 21	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):					
D = 0 8		d. AMENDED AMENDED						
60, ate be e hysicia e buria	Medical	IF FEMALE: 23c. If yes, outcome of pre	gnancy				23d. Date of del	livery
687 certifica ding p	cian/N	23b. Was decedent pregnant in the past 12 months?	2 F	etal death	Ectopic pregn	ancy	Month	Day Year
Box 6876 ne death certificate the attending phy hed for use as the	hysic	1 Yes 2 ✓ No 9 Unknown g Unknown	5 0	ther (Specify)				
	e Se	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause	e given in Part I.			te to the cause of death? Probably 4 Unknown
rds, P.C requires that been signed hould be deta						24a. Was		re autopsy findings available
cords, law requir has been s	Completed						ormed? dea	
		25. Was case referred to medical		26.Pla	ice of Death (Check		2 ✓ No 1	Yes 2 No
of Vital Records, ig Physician: The law requir ther this certificate has been s meral director, page 2 should	e Be	evaminer?	✓ ER/Outpatier	nt 3 DOA	Other Nursi	ng Home 5	Residence 6	Other:
n of Vital I ding Physicians h. After this certifi funeral director,	ä	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Dav Year) Nov 24, 2009	28b. Time of 1013 hrs		njury at Work? Yes 2 ✔ No		how injury occurred struck by auto	
deat deat	ertification:	2 Accident Investigation 28e. Place of Injury - At	home, farm, stre			28f. Location	(Street and Number of	or Rural Route Number, City
Division of the control of the contr	ert	3 Suicide 6 Could not be determined (Specify) Major RD				or Town, Cradlerock V	State) Nay, Columbia, Mo	i
8 4 E 2	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowle one) 2 Medical Examiner: On the basis of examination	edge, death occu	urred at the time, ation, in my opini	date and place, an	d due to the cau at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)
To the within To the comple	Me	and manner stated. 29b. Signature and title of certifier			nse number			(Month, Day, Year)
		J.M.	,	0.0	C.M.E.		November 26	3, 2009
4	İ	30. Name and address of person who completed cause of death (Ite Jack Titus MD. Deputy Chief Medical Examin	m 23a) er 111 Pe	enn Street. B	altimpre. MD 2	1201		
	ite	- A	ature del					
Registr	ar	31. Date filed (Month, Day Year) 32. Registrary Sign.	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** nchson 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charlestown Care Center Catonsville **Baltimore** Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □ F Months Director 213-12-6909 88 MD Dec 18, 1920 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show Injury or other traumatic event, the Medical Exacting quantitied at 1 □Yes 2 ☑No Director MD **Baltimore** Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 711 Maiden Choice Lane or items 23a 21228 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If a Mangones. Elementary/Secondary (0-12) Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bieberich Caroline Lentz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eileen Bieberich sister-in-law 11110-G Chambers Ct. Woodstock, MD 21163 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Nov 30, 2009 Clarksville, Maryland 4 □ Donation 5 □ Other (Specify) St. Louis Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part 1. Enter the disease of shock, or heart failure. List se, o complications that caused the death. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. E Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached for I∐Yes 2.127No 9 Unknown 23e. Did tobacco use contribute to the cause of death! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 2 □ No 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an certificate 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27 No 1 🔲 Inpatient Certification: To 1 ☐ Yes After this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Funeral Director: After the completely filled in by the funeral after death. within 24 hours a

To the Funeral C 4

> State Registrar

Medical

4 Homicide

29b. Signature and title

30. Name and address of

Year)

Vichae 31. Date filed (Month, Day,

29a. Certifier

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Choice LN.

29d. Date signed (Month, Day, Year)

Medical Examiner Alphonso Jackson, Jr. 4a. Facility Name (if not institution, give street and number) 3909 W. Forest Park Avenue Month November 29, 2009 4b. City, Town, or Location of Death Baltimore	3859
Medical Examiner A1 phonso Jackson, Jr. 4a. Facility Name (if not institution, give street and number) 3909 W. Forest Park Avenue Month November 29, 2009 4b. City, Town, or Location of Death Baltimore	me of Death
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 3909 W. Forest Park Avenue 4c. County of Death Baltimore	345 hrs
3909 W. Forest Park Avenue Baltimore	345 1115
Control Country Number C.Co. 7 April 1991 199	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplac	e (State or
216-94-6276 1XXM 2 F 45 Yrs. Months Days Hours Min. March 3, 1964 Foreign Country)	MD
Usual Residence of Decedent	
	Inside City Limits Yes 2 No
Baltimore 10f. Zip Code 10g. Citizen of What Country?	Yes 2 No
MD Baltimore 10. Citizen of What Country? MD Baltimore 10. Citizen of What Country? 4014 Fairfax Road 11. Mantal Status 11. Mever Married 2 XXMarried 11. Mever Married 2 XXMarried 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify: Usban, Mexican, Puerto Rican, etc.) 14. Race - American In White, etc. 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) Alphonso Jackson, Sr. Alphonso Jackson, Sr. Alphonso Jackson, Sr. 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipu Gina, Jackson/Wife) 20c. Location - City or Town, Crematory or other place) 20c. Location - City or Town Crematory or other place) 20c. Location - City or Town Crematory or other place) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 33. Windowed 4 Divorced If Yes, Give Year or Date of Disposition (Name of cemetery, Crematory or other place) 24. Donation 5 Other Specify: 25. Signature of Funeral Service Licensee 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 29. Name and	
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17. Father's Name (First, Middle, Last) Alphonso Jackson, Sr.	
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O of the state of	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town	n, State
The state of the s	MD
GARRISON FOREST 12/09/09 OWINGS MILLS, 22. Name and Address of Facility James A. Morton & Sons	
manes 9 Morton 1701-31 Laurens St. Baltimore, Maryl	_
Physician 236. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Ap	proximate Interval
Medical Homerical Horoin and according intoxication	etween Onset and Death
or condition resulting in death) Immediate Cause (Final oisease or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, b	
if any, leading to immediate Due to (or as a consequence of): Leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
, a 5 % _ l	
23d. Date of delivery	
Compared to the past 12 months? Compared to the past 12 months? Compared to the past 12 months Compared to the past 12	Year
X of the series	
변형 설명 교 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the c	ause of death?
O the second to be contributed to the contribution of the significant contribution of the contribution of	4 V Unknown
24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 1 ✓ Yes 2	y findings available
autopsy prior to complete the c	letion of cause of
autopsy performed? 1 V Yes 2 No 1 V Yes 25. Was case referred to medical examiner? Hospital:	2 No
26. Place of Death (Check only one) 26. Place of Death (Check only one) 4. Solve a seximiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Society of Death (Check only one)	
The spiral of th	ene
28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	
Pending Investigation Fd 11/29/09 Fd 1:40 pm 1 Yes 2 XNo unknown	
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determined (Specify) found at residence Ave. Baltimore, MD	
25. Was case referred to medical examiner? 1 Ves 2 No 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Location (Street and Number or Rural R or Town, State) 3909 W. For Occurred 28d. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury occurred unknown 28d. Location (Street and Number or Rural R or Town, State) 3909 W. For Occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury occurred unknown 28d. Location (Street and Number or Rural R or Town, State) 3909 W. For Occurred at the time, date and place, and due to the cause(s) and manner as stated. Occurred the first of the first occurred at the time, date and place, and due to the cause(s) and manner stated.	ise(s)
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only Chec	
290. Signature and title of certifier 290. Date signed (Month, L	∍ay, τear)
Mu Stanel, MY O.C.M.E. November 30, 2009	
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legisle 9 38597 Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No.

For State Registrar

Physic	oion	Decedent's Name (First, Middle, Last)	V:	2. Date of Death	3. Time of Death
/Med		ALFONSO KING Alfonso	King	Month Da	
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	: County of Death
ng p	4.	UNIVERSITY OF MARYLAND MEDICALEN	TEK BILLING		NA
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last t	oirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year,	9. Birthplace (State or Foreign Country)
Directo		Usual Residence of Decedent	115.	F26 5, 190	eb Maryland
yland yland			wn or Location		10d. Inside City Limits
Many a-fsh	tor	Mal M/a Bo	Himore		1 Nyes 2 No
h the	Director	10e. Street and Number		10g. Ci	tizen of What Country?
h witl		1802 heCilat St	21217		U.S.A.
deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S)	pecify Yes or No-	14. Race - American Indian,
after of it	Fu	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
Z 1 Z 1 3-UU30 4 within 72 hours after death with the Maryland sjene. r than "natural", or items 23a or 28a-f show	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 Li Yes 2 No Specify:		Specify: Black
"nat	Completed	15. Decedent's Education 16. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b. K	(ind of Business/Industry
within iene.	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		211
e filed al Hygi		17. Father's Name (First, Middle, Last)	COOK 19 Matheria Norm	e (First, Middle, Maiden	Cistauran1
d be ental	Be C	1	18. Mother's Nam	e (First, Middle, Malden	Surname)
ire, Midryland, s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked othe other traumatic event,	2	19a. Informant's Name/Relationship (Type. Print)	h Mailing Address (Street and Number of Bu	a Chistu	\$
Michaellthar 1thar 27 is 1trau	1		b. Mailing Address (Street and Number or Ru	ral Houte Number, City (or Town, State, Zip Code)
THear tem other		20a, Method of Disposition 20b, Place	of Disposition (Name of	Date 20c. L	ocation - City or Town, State
3 0 0		2 Desirate La Societation State	ery, crematory or other place)	- 50	A A A
Dallill permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signa, e of Funeral Service Licensee	Name and Address of South	9 2009 15	alto Ad 21202
Dail. permit. Departr Importa any Inju	b b	I OF CA-C	Carling	das tune	ral Service P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do	o not enter the mode of dving, such as cardiac	or respiratory arrest	Approximate
Dhuaiaian	e 10	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	who terror the mode of dying, such as caldiac	or respiratory arrest,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)			
Examiner		Due to (or all a consequence	001):		
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):		
cuted	Examiner	cause. Enter Underlying Cause Unisease or Injury that initiated events C.			
an ar		resulting in death) Last Due to (or as a consequence	of):		
eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	d			
ng ph as th	Jed	IE EEMM E			
eath certific attending p	N/ue	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat	h 2 Tetania nasana		23d. Date of delivery
• 0 0 0		1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day Year
The law requires that the date has been signed by the page 2 should be detached	Physi	3 COUNTOWN			
es th igned	by	Part II. Other significant conditions contributing to death but not resulting i	in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
w requires been sign should be				1 Yes 2	□ No 3 □ Probably 4 🗷 Unknown
law r las be 2 sh	Completed			24a. Was an	24b. Were autopsy findings available
The cate h	NO.			autopsy performed? 1 □ Yes 2 ☑ No	prior to completion of cause of death? 1 □ Yes 2 □ No
iclan: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	26. Place of Deat	(Check only one)	TILITES ZILINO
hysik his o	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/O	utpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specify)
ing P	Ë		Time to the second	28d. Describe how injur	
tendi eath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 ☐ Yes 2 ☐ No		
or At fter d irect	Certification:	4 Homicide determined 28e. Place of Injury - At home, fa	arm, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
oital ours a gral of illed					
Hosp 24 ho Fune tely f	ica	29a. Certifier (Check only and) 1 □ Certifying Physician: To the best of my knowledg. Check only and the pass of examination are constructed to the pass of examination are constructed.	e, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause(s)) and manner as stated. I place, and due to the cause(s)
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	one) and manner stated. 29b. Signature and title of certifier			
F § F 00		The state of the s	29c. License number		te signed (Month, Day, Year)
_1		CHU N.O.	164940551	NOVE	EMBER 28 2009
∇		30. Name and address of person who completed cause of death (Item 23a) MY-LE NGUYEN UNIVERS; TY OF	(Type, Print) MARY [AN] HEDICHL C	ENTER 20	S. GREEN ST. BALTIMOR
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	a D		MARYLAND
Registr		MEA A 9 2000 2 A A COM			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 13:00 P M 2009 King Gordon Frank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 3809 North Crain Hwy. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Ye Aug • 30 • Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NCD **Funeral** 1 🛣 M 2 🗆 F ^{Year}1947 MD 212-52-3374 62 **Director** Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No MD Anne Arundel Severna Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21146 159 Boone Trail . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces' Black, White, etc. <u>Ş</u> 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food & Beverage Mananger Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maureen Delia Olson Gordon Frank King Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Boone Trail Severna Park MD 21146 Mrs Carole L. King/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 Burial 2 X Cremation 3 Removal from State 7, 2009 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee 2nd Ave. Glen Burnie, MD 21061 Services PA 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami requires that the death certificate be executed Cause (Disease or linjury burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veal Day Pregnant at time of death 5 Other (specify) signed by the a 9 I Inknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law r 24 hours after death, • Funeral Director: After this certificate has b page 2 s autopsy death? 1 ☐ Yes 2 No perform 1 Yes 2 lemporary funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Residence Hospital 212No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No injury 1 🗷 Natural 5 Pending Investigation Accident the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 2009 and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

0,6

filed (Month, Day, Year)

DEC 0

3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09195 State of Maryland / Department of Health and Mental Hygiene Joseph Kane 38599 2009 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month November 26, 2009 0938 hrs **Medical Examiner** Kane, Jr. Joseph 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Raltimore Johns Hopkins Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Hours Min Director 64 08/28/1945 MD 216-44-0081 1 X M 2 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No Baltimore Baltimore MD with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21222 1948 Searles Road Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death Never Married 1 X Yes If Yes, Give Year Vietnam Specify: White 4 X Divorced 1 Yes 2 X No specify: Widowed <u>چ</u> Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 MD 21215-0036 Construction Plumber 12 of Health and Mental Hygiene, If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veronica Matthews Joseph <u>Kane</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print 9526 Oak Branch Way Baltimore, MD 21236 Michele Gorsuch, Gaurdian 20c. Location - City or Town, State Owings Mills 20b, Place of Disposition (Name of cemetery, Date Baltimore, 20a, Method of Disposition unknown crematory or other place) X Burial 2 Cremation 3 Baltimore, Maryland Department 12/7/09 portant: Garrison Forest Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. 5305 Harford Road Baltimoré Ruck, Inc , MD 21214 ovanduo 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Compliations of head injury xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and /sician/Medical 28a per ME G899 1/20/10 TT X UNPENDED AMENDED attending physician or use as the burial -3a.27.28a-f.perME. g899 1/6/10 TT be 6 Records, P.O. Box 68760, If yes, outcome of pregnancy 23d. Date of delivery requires that the death certificate 23b. Was decedent pregnant in the past 12 months? Day Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown q Unknown the a 23e. Did tobacco use contribute to the cause of death? signed by the detacher Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? No 1 V Yes 2 No ✓ Yes 2 To the Hospital or Attending Physician; within 24 hours after death. 26 Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 2 V ER/Outpatient 3 this Inpatient 1 Yes 28d. Describe how injury occurred 8a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1X Yes 2 No Natural Pending subject fell from ladder within 24 hours after death To the Funeral Director: the 8/8/2008 10 X Accident am 2 Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide Sinai Hospital, Baltimore MD Hospital determined (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number and title of certifie November 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

14 DEMOX

State 31. Date filed (Month, Day Year)
Registrar

Laron Locke MD.

OCME

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 38600 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛛 F Days Hours Min. 79 Director 216-40-7062 11/22/1930 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or them 27 is marked other than "natural" or them. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Allnut Court #602 Funeral 20678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store 8 Cashier UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Schubert Emily ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Hutton/ Daughter 123 Adderton Drive, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 11/30/2009 Hanover, Maryland 21. Signature of Funeral Service Liansee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 974 **Physician** /Medical Due to (or as a nsequence of): Examiner ervic-Sequentially list conditions Examiner if __i, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a conse burial ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL PRINCE FREDERICK 12000 STE 305 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Mary Magdalene Larson 11/21/2009 4:20am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Collingswood Nursing & Rehab Center Rockville Montgomery if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 9/14/1931 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Months 485-32-3092 78 TA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a State 10h County 117 Yes 2 □ No MD Montgomery Silver Spring Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3503 S. Leisure World Blvd. 20906 Items 23a "natural", or Items 23a edical Examiner ⊓ust Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes SENO If Yes, Give Year or Dates: within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White ģ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical than College (1-4or 5+) Elementary/Secondary (0-12) Government Clerk 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If them 27 is marked on any injury or other traumatic evenone. Be Frederick Christian Zimmerman Marie Saewert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 503 Creek Valley Lane, Rockville MD 20850 Susan Larson-Makar/ Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) Oakland Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State 11/28/2009 Waukon, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Name and Address of Facility CHARLES L. Stevens Funeral Home, Inc. 1501 East Fort Avenue Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ordiac or o shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iratory arrest, immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed that initiated events burial-trai resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? 1 Yes 2 No Month Dav Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No page 2 s 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2√2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 1X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide determined

Division or Vital Records, P.O. Box 68760 or Attending Physician: after death. filled in by within 24 hours a To the Funeral Completely filled Hospital

 Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00062435

29d. Date signed (Month, Pay, Year)

Medical

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAYFID FICAYYAD JULIO NateCular B. EISAYYAU 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09223 State of Maryland / Department of Health and Mental Hygiene Drew W. Landis Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) Physician/ Month November 27, 2009 1426 hrs Medical Examiner William Landis Drew 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Talbot Easton Memorial Hospital Easton 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Country Min Months Days Hours Pennsylvania Jan 30, 1940 Director 69 173-30-0019 1XXM 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No s 23a or 28a-f show e notified at once. Talbot Easton MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code USA 26561 Arcadia Shore Rd. 21601 14. Race - American Indian, Black, Funeral 11 Mantal Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married 2 X Married 1 X Yes Specify: White Yes 2 X No specify: If Yes, Give Yea Widowed 4 Divorced "natural" 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Manufacturing 4 Human Relations 12 marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pennypacker Fern William S. Landis Department of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is P.O. Box 32, Pennsburg, PA 18073 Fern Fite (mother) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 2 Cremation 3 X Removal from State t: If i Burial 11/30/09 Hellertown, PA East)Penn Crematory Donation 5 Other Spe 22. Name and Address of Facility
Fink Funeral Home nature of Funeral Service 21061 426 Crain Hwy. S.,Glen Burnie, Md. Approximate Interval r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the Physician Between Onset and ilure. List nΙν on each line. Death /Medical Drowning complicating Hypertensive Atherosclerotic Cardiovascular Disease e Cause Final dise Examiner or condition resulting in death Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X AMENDED ysician burial -UNPENDED G898,12/3/09,WS Item#22perFH Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy the attending phyned for use as the b Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 ✔ No 3 Probably 4 Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available this certificate has been autopsy prior to completion of cause of death? performed? Yes 2 ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner's Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 2 Y ER/Outpatient 3 Inpatient ٩ 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27 Manner of Death Subject fell in covered pool and drowned <u>...</u> FOUND: 1 Natural Yes 2 V No Pending Certificati

the Hospital or Attending Physician: Division death. Director: the in by within 24 hours a To the Funeral I completely

No Nov 27, 2009 1245 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) 26561 Arcadia Shores, Easton, MD determined (Specify) Pool 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 2 🗸

do 30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 28, 2009

31. Date filed (Month, Day State Registra

cal

29b. Signature and title of certifie

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** CARL HERBERT LICHTMAN DECEMBER 01 2009 12:29P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND HOSPITAL BALTIMORF 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral 1** M 2□ F Days Hours Months 64 110-34-2724 Director 09/06/1945 NY Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State 28a-f show other traumatic event, it will be like must be notified at 1 ☐ Yes 2 No Funeral Director FL PALM BEACH LAKE WORTH 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 7785 ROYAL CALAIS DRIVE 33467 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married X Married 1 □Yes 2 No 3altimore, Maryland 21215-0036 ò Specify. If Yes, Give Year or Dates Be Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced WHITF 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PSYCHOLOGIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental - Important: If them 27 is more any injury or other. Mental LICHTMAN ROSENTHAL ၉ **BERNARD** BERTHA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7785 ROYAL CALAIS DRIVE, LAKE WORTH, FL 33467 STACEY LICHTMAN/WIFE 20b. Place of Disposition (Name of ETERNAL crematory in other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3X Removal from State 12-02-2009 BOYNTON BEACH, FL 4 Donation 5 Dother (Specify) MEMORIAL GARDEN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EMBOLISM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed the burial-tran Box 68760.5 resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed KIDNEY TRANSPLANT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 17No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

S. GREENE ST. BALTIMOREZ1231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death **Physician** memor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yes March 29 Birthplace (State or Foreign Country) . Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Days 1 ☑ M 2 ☐ F 74 Yrs. VA 1935 Director 228-40-1109 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 x No Director Pasadena Maryland Anne Arundel 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or USA 21122 1218 South Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. than Clergy Religious 5+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be S. Shifflett Ethel C. Morris Vernon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) and is m 1218 South Road, Pasadena, MD 21122 (spouse) Health a Portia M. Morris If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Holly Memorial Cem. Charlottsville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service License 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or c. medical one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart heliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Box 68760, R Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 TYes 1 Tyes or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) in by the funeral director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural
2 Accident Injury 1 🗌 Yes 2 🗌 No death. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 GROVES MARI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AN VAL HA 3 2009 DEC 0

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene o For State Registrar 38605 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 100 Emage Lexie Reba Mallonee :052 M 200 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BURNIE SALTMORE DAFHINGTON MEDICAL AFINE Cien If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Dec. 4, 1923 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Country) Virginia 1 □ M 2 😾 F 225-12-2688 85 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified 1 🗆 Yes 2 🖁 No Severna Park Anne Arundel Co ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 Funeral items 23a 668 Ellerslie Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or i ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 21215-0036 1 Yes 2 No Specify. Specify Completed 3 K Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 6 yrs. Be filed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Hansberger MALLONEE Turner Hepner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 554 Jandon Court Millersville, MD 21108 Mrs. Brenda A. Fegley/ Daughte 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) 12/03/2009 Sykesville, Maryland Lakeview Mem. Park 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Se Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ TULMONAR: Medical resulting in death) Examiner CESTIVE if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death. Director: After this 27. Mannal of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certifier o 4514 address of person ho completed cause of death (Item 23a) (Type, Print) 301

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Registrar

31. Date filed (Month, Day,

3

Darks

2. Registrar's Signature

38606

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Funeral Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Marical Experiment is as be institled at apine.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician /Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
15

	1	State Registrar		Cei	rtificate of L	Death	Reg.	No.				
ion		1. Decedent's Name (First, Middle, La					2. Date of Death _Month	Day Year	3. Time of Death			
ian ical	ŀ	DIANE SUE	MONHEIT				1	2009				
ner	1	4a. Facility Name (If not institution, gi				Location of Death		4c. County of Dea BALTIM				
		7101 TRAVERTINE 5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthdav)	BALTIMOI If Under 1 Year	If Under 24 Hrs.	8. Date of Birth					
	1		. —	75 Yrs.	Months Days	Hours Min. 0	13/05/193	1 Co	thplace (State or Foreign ountry) NY			
	\vdash	Usual Residence of Decedent	140.00	v. Town or Lo					10d. Inside City Limits			
-	- 1	10a. State 10b. County		1 □Yes 2 No								
Director	-	MD BAI	LTIMORE B	BALTIMO	10f. Zip Code		10g.	10g, Citizen of What Country?				
ä		7101 TRAVERTIN	E DRIVE, #203			21209			USA			
Funeral	-	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi	ispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No-	14. Race - Ame Black, Whit				
Fu		1 Never Married 2 Married		I	il ⊟Yes 2 🛣 No	Specify:	ilouri, Cto.)	0				
od by	-	3 Nidowed 4 □ Divorced	Year or Dates:	16a Docor	dent's Usual Occup	ation	16h	Kind of Business	HITE /Industry			
Completed	-	15. Decedent's E	rade completed)	(Give	kind of work done of NOT use retired	during most of working	g	Talle of Buoincoo	The door y			
mo.		Elementary/Secondary (0-12)	College (1-4or 5+)			OWNER	SUI	RVEY RESE	EARCH ASSOC.			
Be		17. Father's Name (First, Middle, Las		/1 ETNDE	.DC		(First, Middle, Maid	e, Maiden Surname)				
၉	DENIAMIN VIETNREDC MAE MONHE											
		19a. Informant's Name/Relationship MICHAEL MONHEIT		1	-	RY RD., BA			21209			
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Hemoval from State DA		sition (Name of natory or other plac			Location - City or				
	-	BALTIMORE HEBREW 12/03/2009 REISTERSTOWN, MD 21. Stigntfure of Funerall Service Accepted 22. Name and Address of Facility SOL LEVINSON & BROS., INC.										
		MALANINI	Musec						E, MD 21208			
	Ť	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deatl	h. Do not ent	er the mode of dyin	ig, such as cardiac or	respiratory arrest,		Approximate Interval Between			
ı		Immediate Cause (Final disease or condition	hepatic						6 worths			
		resulting in death)	Due to (or as a consequ						20			
in its		Sequentially list conditions,	b. priwary Due to (or as a consequence)		ry civi	10515			20 years.			
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	derioe oi).								
		resulting in death) Last	C Due to (or as a consequ	uence of):			- 					
Medical		•	d									
Mec	-	IF FEMALE:	Official automo of program	2001								
Physician		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl death 3 ∟	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	Day Year			
hysi		1 □Yes 2 MaNo 9 □ Unknown	9 Unknown									
by P	,	Part II. Other significant conditions	contributing to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobaco		o the cause of death?			
led			***				1 ☐ Yes	2 X No 3□ P	robably 4 Unknown			
Completed							24a. Was an autopsy	24b. Were a prior to death?	utopsy findings available completion of cause of			
ပ်	L						performed	No 1 ☐ Ye	s 2 🗆 No			
Be		25. Was case referred to medical examiner? 1 ☐ Yes 2 ★No	Hospital: 1 Inpatient 2	ER/Outpatier	t 3 DOA Othe	er: 4 Nursing Hom	(Check only one) ne 5 Residence	6 □Other (Sp	noifu)			
n: To	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury			8d. Describe how in		ocity)			
atio		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	on	lingury		Yes 2 □ No						
Certification: To		3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
al Ce	-	29a. Certifier 1XCertifying P	Physician: To the best of my kno	wledge, death	n occurred at the tir	me, date and place, a	and due to the caus	e(s) and manner a	as stated.			
Medical		(Check only 2 Medical Exa	aminer: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)			
Ž		29b. Signature and title of certifier	/ Pleit MO		29c. License			Date signed (Mon				
		* // Mill	peur mo		10	UST175	/	101/2	7			
		30. Name and address of person who	o completed cause of death (item Belinfsor	n 23a) (Type, I	Falls A	ed # 201	o Luth	ewille	, MP 21093			
ate		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture								
trar		DEC 0.9.20	1114 /2	A 100	Experience							

3. Time of Death

10d. Inside City Limits 1 Yes 2 No

unk

Baltimore 9. Birthplace (State or Foreign Pennsylvania

7:57PM

		•	State Registrar			,	Cer	tificate d	of Death)	,	Reg. No.		
			1. Decedent's Name (First, Middle,	Last)							2. Date of De	eath	V	3. Time
	Physicia Medic		Adelaide D. Mu	1ford							NUVEN	BER 26	Year.	09 7:
	Examin		4a. Facility Name (if not institution, Saint Jose			Cer	iter	4b. City, Tov	vn, or Locatio	n of Death To⊌s	s o n	4c. Cour	ty of Dear	th ltimo
	Funeral Director		5. Social Security Number 216–28–5395	3. Sex 1 ☐ M 2 💢 I		n yrs. la: 83	st birthday) Yrs.	If Under 1 \ Months D	ear If Und	er 24 Hrs. Min.	8. Date of Bi (Month, Da Jan 24	rth ay, <i>Year)</i> 1926	g. Bir Co Pe:	thplace (Stat ountry) nnsy1v
	d ow t		Usual Residence of Decedent 10a. State 10b. County		1	Oc. City	Town or Loc	eation						10d. Inside
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	/ith th	<u>ra</u>	6 Brooking Cour	t. #202				1011 216 00	21093			J	SA	odita y :
	ems ems	Ĕ.	11. Marital Status	12. Was De	ecedent Eve	r in U.S.	13. V	Vas Decedent	of Hispanic (Origin? (Spe	cify Yes or No	- 14. R	ce - Ame	rican Indian,
39	s after de al", or it Examine	ρ	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	Armed 1 Ye If Yes, 0 Year or)		Yes, specify			Rican, etc.)	Speci	ack, Whit fy: w l	e, etc. nite
9	hours natur fical I	lete	15. Decedent	's Education			16a. Deced	ent's Usual O	ccupation	1 6		16b. Kind of	Business	Industry
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	Completed	(Specify only highes Elementary/Seconday (0-12) 12		(1-4 or 5+)		life. DO	(Give kind of work done during most of working life. DO NOT use retired) salesperson						
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yla	ld be Ment arker atic e	욘	Harry Barton	Harry Barton DeVinny					N	ellie	Isabel	Bice		
Mar	d 2 should be file alth and Mental I 127 is marked o or traumatic eve		19a. Informant's Name/Relationshi Patricia Sauer		r		19b. Mailin 7 Te	g Address (St aneck	reet and Nurr Court	ber or Rura Timon	ium, MD	er, City or Town 21093	State, Zi	p Code)
e,	of He of He fitem r othe		20a. Method of Disposition	D	C4-4-			sition (Name o		[Date	20c. Location	ı - City or	Town, State
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Balt	permit. Departr Imports any inji		21. Signature of Euperal Service S	enswade,	A SHE	tor		ate and 1timor		Board 2120		Baltin	nore	Stree
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إيسر	Physician/		shock, or heart failure. List or Immediate Cause (Final disease or condition			no.	JEL O	BSTRU	TTON					Interval E Onset ar
	Medical		resulting in death)		to (or as a c			OD I NO	2 1 1 C3 N					- F 1000
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	_ +	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		to (or as a c	onseque	ence of):							
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	e exe	alE	resulting in death) Last Due to (or as a consequence of):						1):					
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687			IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, o	outcome of	pregnan	су					234 [ate of de	liven
Box	ath cert attendir I for use	iciai	in the past 12 months? 1 Yes 2 No	4 🗌 Pr	ve Birth 2 egnant at ti			Ectopic preg Other (specif					lonth	Day
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P.O.	s that gned b	by F	Part II. Other significant condition	_			_		_	rt I.		tobacco use co	_	
ds,	requires the been signal should be	ted	CHRONIC O	STRUC	LIAE	PUL	AMOMA	(I DIS	EASE		1 X	Yes 2 □ No	3 ∐ P	robably 4
Division of Vital Records,	Physician: The law requires that the death cer r this certificate has been signed by the attendi aral director, page 2 should be detached for use	Completed by Physician/	CORONARY	ARTERY	DISE	ASE							prior to death?	topsy finding completion o
ᄪ	an: T tifica tor, p	Be C	25. Was case referred to medical					2	6. Place of D	eath (Check	_	2 (8) 110	1 🗀 100	5 Z43110
Zi:	ysici iis cer direc	To E	examiner? 1 Yes 2 No	Hospital:	☐ Inpatient	2 3 E	R/Outpatien	t 3 🗆 DOA	Other: 4 \square	Nursing Ho	me 5 🗆 Resi	dence 6 0	her (Spec	ify)
oţ	ding Ph th. After th funeral	ite:	27. Manner of Death 1 Natural 5 ☐ Pending		te of injury o <i>nth</i> , <i>D</i> ay, Y		28b. Time of injury	28c.	Injury at work?	2	28d. Describe	how injury occu	rred	
ion	Attending or death. sctor: After by the fune	ific	2 Accident Investiga 3 Suicide 6 Could n	ation					1 Yes 2					
Divis	i Pirate	l Cert	4 Homicide determin	28e. Pla	ce of Injury Iding, etc. (S		ne, farm, stre	et, factory, of	fice		28f. Location (City or Tou	Street and Num wn, State)	ber or Ru	ral Route Nu
	To the Hospital of within 24 hours a To the Funeral Completed filled it	Medical Certificate:	(Check 2 Dedical Ex	Physician: To the aminer: On the l lurse Practions	oasis of exar	nination	and/or invest	gation, in my	opinion, death	occurred at	the time, date	and place, and c	ue to the	cause(s) and
	To the To the company	-	29b. Signature and the o certifier	\wedge				29c. Lic	cense number			29d. Date sign		
									กรเสสสส			31/7	610)٩

timore Street Approximate Interval Between Onset and Death 4-5 HOUR 4-5 HOUR UNKNOWN 23d. Date of delivery Month se contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other (Specify) occurred Number or Rural Route Number, d manner as stated. and due to the cause(s) and manner stated. and manner as stated. e **s**igned (Month, Day, Year) 26/09 DRIVE TOWSON, MARYLAND

State Registrar M.

30. Name and address opperson who completed cause of death (Item 23a) (Type, Print)

ANDINGHAM

32. Registrar's So

TAMIN

31. Date filed (Month, Day, Year) 009

NOVEMBER 28, 2009 12:15 a.m.

WALTER MCDONALD

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 3 Certificate of Death													38608				
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)								2. Date of De		av Ye	ar	3. Time of Death		
	Medic		WALTER C. McDONALD NOV. 28, 2009												1215 ам		
	Examin	er											4c. County of Death BALT I MORE				
	Francis		5. Social Security No	7 Age/	ge (In yrs. last birthday) If Under 1 Ye									loop (State or Ferrica			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a Sany injury or other traumatic event, the Medical Examiner must be notified at once.		230.14.462	0	6. Sex 1 XXM 2 □ F 7. Age (In yrs. la 85								ay, Year)		Birthplace (State or Foreign Country) VIRGINIA		
		Director	Usual Residence of 10a. State	Usual Residence of Decedent 10a. State 10b. County			10c. City, T	own or Loc	cation						10	Od. Inside City Limits	
			MD	RD	EDGEWOO										1 ☐ Yes 2√1X No		
		ρ	10e. Street and Nun			EDUENO			10f. Zip Code				10g. Citizen of \				
		Funeral	2016 HANSON RD.				21040						J	USA		,	
		문	11. Marital Status		12. Was Dec					Hispanic O	Hispanic Ongin? (Specity Yes or No- pan, Mexican, Puerto Rican, etc.)			14. Race - American Indian,			
21215-0036		by	1 XXNever Married 2 ☐ Married 1 XXYes 2 ☐ If Yes, Give Year or Dates.			2 □ N ve	□ No WWII 1 □ Yes 2 □ No							Black, White, etc. Specify: WHITE			
ò		lete	15. Decedent's Education				16a. Decedent's Usual Occupation				16b.			. Kind of Business Industry			
218		Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)					(Give kind of work done during most of working life. DO NOT use retired)									
		Be C	12 3 FIELD E						ELD BIOLO	ogist				U.S. GOV.			
Maryland		To B	17. Father's Name (First, Middle, Last)				18. Mother's Nan					ne (First, Middle, Maiden Surname)					
ž			BRUCE McDOI				— т	401 44 77									
Ma			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State PATRICIA F. SPANGLER NIECE PO BOX 5375, ROCKVILLE, MD 20848										Zip Ci	ode)			
ē,			20a. Method of Disp	osition			20b. Plac	ace of Disposition (Name of D				Date	20c. L	Location - City or Town, State			
Baltimore,		100	1 WBurial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)				cemetery, crematory or other place) MOUNT HEBRON CEMETERY DEC. 2					2, 2009	09 WINCHESTER, VA			, VA	
Ball			21. Sign for a f Funeral Service Licensee 2. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S., GLEN BURNIE, MD 21061														
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												Approximate Interval Between		
	Physician/	6 0											Onset and Death				
	Medical Examiner																
Į.		ner	Sequentially list co- if any, leading to im- cause. Enter Under	nditions, mediate	b. Due to	(or as a	consequen	ce of):							+		
3	cuted		that initiated events														
0		edical Examiner	resulting in death) l	_ast	Due to	Due to (or as a consequence of):											
200					d												
89		Completed by Physician/M	IF FEMALE: 23b. Was decedent		23c. If yes, ou	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of delivery		ry	
Box 687			in the past 12 months? 1							icy				Month Day Year			
P.O.		y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute			e to the	e cause of death?		
ds, I		q pa											1 ☐ Yes 2 ☐ N		No 3 🗆 Probably 4 🛣 Unknown		
of Vital Records,		ple									24a. Was		24b. Were autopsy findings available prior to completion of cause of				
Re	The la	Con									perfo	performed? death? 1 Yes 2X No 1 Yes 2			2 □ No		
tal	sician: The certificate rector, pag	Be	25. Was case referre examiner?		Hospital:		· · · · · · · · · · · · · · · · · · ·			Place of Dea	ath (Check	only one)					
Ž	To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	2	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPI											HOSPICE			
o uo		cate	1 X Natural 2 Accident	5 Pendin	g (Mon	(Month, Day, Year) injury work?							ld. Describe how injury occurred				
Division		Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	lot be 28e. Place of Injury - At home, farm, street, factory, office						2	28f. Location (Street and Number or Rural Route Number,					
Ö	oital o																
	To the Hosp within 24 ho To the Fune completed f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
			29b. Signature and title of certifier 29d. Date :										e signed (Month, Day, Year)				
			1/1	my	, Hav	1	GN			5760	24		/	1/30/	20	09	
	15		30. Name and addre							утъ	ONTIN	wг. тмп о	1002	?			
	Stat	te	JENNIFER HAUF, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2009 22. Registrar's Signature														
Registrar UEU 0 3 2993 P. A.																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 27 Neventer 200 **Physician** PHOL /Medical 4c. County of Death 4a. Facility-Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Hours 1XX M 2 □ F 215.13.7503 27 FEB 22, 1982 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director WASHINGTON **HAGERSTOWN** 1 ☐ Yes 🎗 💢 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 11542 TWINEBRIDGE CT. 21742 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ②☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XX Never Married 2 Married 1 ☐ Yes 2 💢 📉 No Specify WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **SERVER** HOSPITALITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be DOUG W. McKENZIE, SR REBECCA COOK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REBECCA COOK 48 TIDEWATER TERRACE, FALLING WATERS, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY DEC. 3, 2009 GLEN BURNIE, MD of Funeral Service Liceg 22. Name and Address of Facility FINK FUNERAL HOME, P.A. FINK 426 CRAIN HWY, S., GLEN BURNIE, MD 21061 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. nter the disease Approximate heart fa Interval Between shock, Onset and Death Immediate Cauce (Fina OFACH **Physician** disease or conditi resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available Be

or Attending Physician: The law requires that the death certificate be executed burial-tran Box 68760. as completely filled in by the funeral director, page 2 should be detached for use P.O. Division of Vital Records, s after death

ပ Certification:

27

Medical

State

25. Was case referred to medical		
examiner?	Hospital: 1 Inpatient	2 FF

						26. P
Н	ospital: 1 Inpatient	2 🗆	ER/Outpatient	3 🗆 [OOA	Other: 4
	28a. Date of Injury		28b. Time of			Injury at

	autopsy performed? 1 X Yes 2 \(\subseteq \text{No} \) 1 X Yes 2 \(\subseteq \text{No} \) 1 X Yes 2 \(\subseteq \text{No} \)
26. Place of Deat	th (Check only one)
other: 4 \sum Nursing He	ome 5 Residence 6 Other (Specify)
jury at ork? □ Yes 2 □ No	28d. Describe how injury occurred

examiner?	0	Hospital: 1 Inpatient	2 ER/Outpatient	3 🗆 D	OA Other: 4	Nursing Ho	me 5 Residence	6 Other (Specify)
. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Yea	z8b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2		28d. Describe how inj	ury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - building, etc. (St		t, factor	y, office		28f. Location (Street a	and Number or Rural Route Number, e)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier dicah Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one)

► /// ///		RES-000	Nove
29b. Signature and title of cert	fier	29c. License number	29d. Date si
	29b. Signature and title of cert	29b. Signature and title of certifier	RES-000

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

agaret Registrar's Signature 31. Date filed (Month, Day, Year,

oarko

thin 24 hours

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 3:30 PM Deal OS ames /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care Canton Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 212-76-0149 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1XXXM 2 □ F 60 8/1/1949 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Show MD N/A Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f sh any injury or other traumatic event, the Medical Examiner must be notified a once. 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 E. Fort Avenue 21230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2k No If Yes, Give 1X Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify: 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 0 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward R. Neal Margaret Frank 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 421 E. Fort Avenue, Baltimore MD 21230 Edward Neal / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 11/24/2009 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Signature of Funeral Service Licensee Victor P. Doda, Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fou cuts nevoluna disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) Ö I □Yes 2 □ No 9 Unknown σ. signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate | 1 ☐Yes 2 ☐No Hypotin 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation spital or Attendin nours after death. neral Director: Af / filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (*Month*, *Day*, *Year*) 29c. License number 29b. Signature and title of certifier 208 PIA liteal le coarmos 63 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ritchetti Mary +508 Chen Borner, Maryland 2106/ 730 twast & Williach 32. Registrar's signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** P^{M} 2009 December 1, 4:30 Patricia Ann Ohl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕏 F Months Hours 62 212-54-5579 August 11, 1947 Washington, D.C. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 1√ Yes 2 □ No Directo Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 20851 United States items 23a 1209 Parrish Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or itel 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Francis Edward Draley, Jr. Rachel House 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is or other tra Christopher M. Ohl/Son 1520 Saratoga Blvd., Indian Trail, NC 28079 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State December 3, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2009 Silver Spring, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Malignant Neoplasm of the Uterus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 2 □No 1 ∐Yes 2 🔀 No 1 ☐ Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(\text{Hospice} \) 1 Yes 2 √No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier · Koucetchou, MD D63748 December 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway, Baltimore, Maryland 21218 Jocelyne Kouatchou, M.D.

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND, TTEM#25perVERB, G898, 12/3/09, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:11 PM 2009 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month Day 1 □ M 2 🗷 60 Yrs. Hours Min. Director 466 or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MI a Himore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status 14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ondar (0-12) College (1-4 or 5+) Be 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street MD 212-15 lace of Disposition Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other p 9-2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicense Funeral Services Hn. MD21229 5151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Asthma Physician/ Exacerbation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner congestive Henre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner CArdioMyo schemic the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 W No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnous peen ; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending the Funeral Director; Aff work? 2 🗆 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) and le NOVEMBER 30. DDDS 2490 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. ygnova St. Balkmine 3001, 21221 Khan de /wal MI 31. Date filed (Month, Day, Year) 32. Registrar' Signatu State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per Inf G898 12/23/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 5:28 A Physician November 24, 2009
4c. County of Death Peav 1,2 abeth /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 287-48-3661 1 - M 2XX 2/12/1949 60 OH Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show notified at Prince Georges Greenbelt MD 1 XYes 2 No Director 10g. Citizen of What Country? e. Street and Number 6700 Lake Park Drive 10f. Zip-Code with ō 20770 USA ral", or items 23a o Examiner must be Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: XX Never Married 2 Married 2 **XX**0 1 Yes 2 XXo Black Baltimore, Maryland 21215-0036 Specify Specify: δ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) event, t 17. Father's Name (First, Middle, Last) Be Ith and Mental H 27 Is marked of traumatic ever Gloria Brown James Peavy p Sister 19a. Informant's Name/Relationship (Type. Print)

Judith Singletary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13402 Katrinka Drive, Bowie Health tem 27 I other 20b. Place of Disposition (Name of cemetery, crematory or other place Glendale Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 KRemoval from State 12/1/09 Akron, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Ave, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition ACUTE RESPIRATORY DISTRESS SYNDROME DAYS **Physician** ጔ resulting in death) /Medical Due to (or as a consequence of): **Examiner** DAYS SEVERF SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) DATS エNFLUV2A physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown ate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 No 26. Place of Death Check onl one funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ٩ 28a. Date of Injury this 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: s after death. I Director: After t 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide 24 hours Excitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 00067327 NOVEMBER 34, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY F BURNS 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOV. ¹2^y6,20^y0³9 **Physician** 1912P ^M Samuel C. Patrinicola /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Rel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Sex 1 M 2 □ F 8. Date of Birth 11-1-1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours MD 216-14-4203 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State s 23a or 28a-f show Harford 1 XYes 2 □ No Forest Hill MD Director 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 21050 700 Bernadette Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: White ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Menta Josephine Livolsi Angelo Patrinicola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann Patrinicola- Wife 700 Bernadette Drive, Forest Hill, MD 21050 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Seremation 3 ☐ Removal from State Bayview Crematory 11-28-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 21222 2134 Willow Spring Road, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZEMBY Z **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes 2 XNo certificate Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 □ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

atrinicola. S

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38615 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2211 M EMINGTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Anne Arundel Anne Arundel Medical Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 - F Hours 578-68-7075 D.C Director 60 10/07/1949 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director MD Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1135 Bay Ridge Road 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Rlack. White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Barber Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bay Ridge Road, Annapolis, MD 21403 1135 Mario A. Rojas / Friend, POA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State remeter, crematory or other place)
Final Journey Crematory 12/3/2009 1 🗋 Burial 2 🔀 Cremation 3 🗆 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Facility
Maryland Cremation Services ice LicenseeDorota Marshall W: Ma 1413 Baltimore, MD 21203 PO Box 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 G 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **M**o မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Simature

Michael LaPenta, M.D. 2001 Medical Parkway, Annapolis, MD

		For	State	of Maryland		artment rtificate		ealth and M	lental Hy	giene	2009	38616	
		Registrar 1. Decedent's Name (First, Middle	(act)		061	incare	010	- Catir	2. Date of De	ath		3. Time of Death	
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		if Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da	av Vearl	Cor	nplace (State or Foreign untry)	
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or He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from	m State Mor	Place of Disponentery, cre	osition (Nai ematory or i rv	me of other plac	e) Decemi	ber 3,				
Pag ment ant: h		4 ☐ Donation 5 ☐ Other (5	Specify)	Cre					009	Bet	hesda,	Maryland	
BAITIMORE, IMARYIANG ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	License	W01/6	NO R	2. Name a	ille,	Inc. 30	J West	Mont	gomery	neral Home/ Avenue	
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Division or Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 X Certify	ing Physician: To at Examiner: On th	the best of my kn	owledge, de	ath occurre	ed at the ti	ime, date and place	e, and due to t	the cause(s) and manner a	as stated. ue to the cause(s)	
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\		31. Date filed (Month, Day, Yea	v) 1/10, 7	2. Registrar's Sign	pature /	O P	ir tr	100	10,000	11111	-1011-3		
	State strar	DEC 03	2009	upu p	1. Apa	ALES							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sobertson **Physician** 10:23AM n) overuber 40 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore TRESTLE WOOD COURT Ravidalltown 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 12 M 2□ F Months Days Hours Min. 215-24-06711 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, trainwaller Examinations mailted 1 ☐ Yes 2 ☑ No Baltimore Md. Randalttown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Trestle Wood Court 0514 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Labor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UKN 2 VKn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. COURT Kandalltown Md. 21133 Rebertson IRESTLE Neod Walter 20b. Place of Disposition (Name of cemetery, crematory or other place),
WDD dhown Cemetery 20c. Location - City or Town, State Date 20a. Methed of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09 Woodlawn, Net. 22. Name and Address of Facility Malapy Nother Polling Chapel P. C. 21. Signature of Funeral Service Lice Broadway 23a Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 10 Uascul Lan Leniose Due to (or as a consequence of) oughtfelly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical as attending 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Ye ar 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 **N**0 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident

Examiner Funeral Director Baltimore, Maryland 21215-0036 2 should be finance and Mental F permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev **Physician** /Medical Examiner certificate be executed Box 68760. Division of Vital Records, P.O. completely filled in by the funeral director, Certification: or Attending after death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 500S 30. Name and address of person who completed cause of death (Item 234) (Type, Print) 0 121W 32. Registrar's S 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Serie of Maryand? Department of Health and Mental Hygiene

			For State of Maryland / D State Registrar	Certificate of Death	Reg. N	2009 38618		
ŀ	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death 02:20 AM		
2	/Medic	al	Josephine Whatley Smith 4a. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Dear		29 2009 02:20 A*		
	Examin	er	Friends Nursing Home	Sandy Spring		Montgomery		
	Funeral Director		420-20-1920	Hoday) If Under 1 Year If Under 24 Hrs Months Days Hours Min				
	/land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town			10d. Inside City Limits		
	e Mary ka-f sh tifled	Director	MD Montgomery I	Derwood		1		
	th with th 23a or 28 ust be no	al Dire	10e. Street and Number 16408 Kipling Road	10f. Zip Code 20855		Citizen of What Country? U.S.A.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	ithin 72 ho ne. nan "natul Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking	Kind of Business/Industry Wn Home		
121	filed w Hygier ther th		17. Father's Name (First, Middle, Last)	omemaker 18. Mother's Na	me (First, Middle, Maid			
au	lid be fental rked o	To Be	John Whatley	ine Smoot				
Mary	and 2 should beath and Ments n 27 is marked ner traumatic e		19a. Informant's Name/Relationship (Type. Print) Douglas Smith/Son	Mailing Address (Street and Number or F 16408 Kipling Road,	ural Route Number, Cit Derwood, M	y or Town, State, Zip Code) D 20855		
Baltimore,	Pages 1 annent of He		20a. Method of Disposition 1 □ Burial 2 □ XCremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of cemeter Ardent (Disposition (Name of y, crematory or other place) Cremation Services 12/0	02/2009 Ha			
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee Zama C. Hardeste Moll97	22. Name and Address of Facility A 7522 Connelley Dr	ive, Ste.N,	tion Servcies Hanover, MD 21076		
F			23a. Part1. Enter the disease, or complications unit caused the death. Do n shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	ic or respiratory arrest,	Approximate Interval Between Onset and Death		
\mathcal{E}_{i}	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence	Artery Dream) C	10 years		
b	Examiner		Sequentially list conditions, b.	nf),				
	nted Insit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	סו):				
30,	oe exectician and unial-tra	I Exa	resulting in death) Last Due to (or as a consequence of	of):				
68760,	ficate b physic s the b	edical	d			Г		
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year		
	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?		
ords	w requires been sign should be	ted b	Dysphogia, Pacumodia		1 ☐ Yes	2 No 3 Probably 4 Unknown		
Reco	he law r has be ge 2 sh	Completed	Dysphogia, Pacumowia		24a. Was an autopsy performed			
ta	sician: The law certificate has birector, page 2 s	Be Co	25. Was ca eferred to medical	26. Place of De	1 Yes 2	No 1 □ Yes 2 12 No		
\ \	hysich this cer al direc	To B			Home 5 ☐ Residence			
ono	ding Phys h. : After this funeral di	tion:		Fime of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred		
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and pla d/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
			1 Klins	Time Print	Dec	emor 2, 2001		
	6		30. Name and address of person who completed cause of death (Item 23a) (ARTHIR SCHOENGULP, MD 18	Type, Print) 111 Prive, Ph. 1. p Drive	OLNG,	MD 20832		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	exted				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09126 State of Maryland / Department of Health and Mental Hygiene Michael A. Sellers 2009 38619 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 23, 2009 2332 hrs Medical Examiner Michael Anthony Sellers 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Country Washington IC Director 01/30/1963 577-82-1706 47 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be abotified at once. Prince Georges Capital Heights MD Director 10g. Citizen of What Country 10e. Street and Number U.S.A. 20743 5116 Doppler Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces 1 Never Married Yes Black Specify: Yes 2 X No specify: 3 X Widowed If Yes, Give Year Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) N/A Unemployed Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Rosa L. McRae Woodrow Sellers, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1702 Pepperbush Ct., Crofton, MD Randy McRae/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Ardent Cremation Services 12/02/2009 Hanover, Maryland Donation 5 Other Specify: 22. Name and Address of Facility MidAtlantic Cremation Society 21. Signature of Funeral Service Licensee MO1197 7829 Belle Point Drive, Ste.B. Greenbelt. MD C. Hardesly 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death M. dical Hypertensive heart disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 23a, PII, 27, perME, g898 12/10/09 TT tending physician use as the burial • Hospital or Attending Physician: The law requires that the death certificate be eath hours after death.

• Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b be detad 1 Yes 2 No 3 Probably 4 V Unknown 호 Congestive heart failure; chronic alcohol abuse Completed Division of Vital Records, 24b. Were autopsy findings available has been s 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 2 No certificate h ector, page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 examiner? Residence 6 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1X Natural Yes 2 No Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the] and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

ORIGINAL

Assistant Medical Examiner

32 Registrar's Signatur

O.C.M.E

111 Penn Street, Baltimore, MD 21201

November 24, 2009

DOME

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month) Day Year) 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38620 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ Seitz 2009 7:20P M George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1039 Park Road Crownsville Anne Arundel Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days April 25,1941 Country) 214-40-0073 68 MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1039 Park Road 21032 U.S.A. items 2 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 Specify: White 1 Yes 2 X No If Yes, Give Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ္ရ should be George Seitz Norma J. Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 sh tment of Health a rtant: If item 27 is Ms. Kim Seitz /Daughter 8685 Lake Drive Snellville, GA 30039 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9 December Important: I any injury o 4 Donation 5 Other (Specify Atlantic Crematory Glen Burnie, MD Signatu Funeral Sen 22. Name and Address of FacilitySingleton Funeral & Cremation MOIZZO Services PA 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATK Physician/ TIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami nding physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for u in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown the (detached s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown Records, 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? 1 ☐ Yes 2 ☐ No this certificate **Division of Vital** Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 No Investigation Accident 6 Could not be Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 9009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, Glen Burnie MD 21061 RAIN HW

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09240 State of Maryland / Department of Health and Mental Hygiene Fortune Schefield 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Fortune Clarence Schefield, Jr 2. Date of Death Physician/ November 28, 2009 1323 hrs **Medical Examiner FORTUNE** SCHEFIELD 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Baltimore 3610 Fairview Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. Funeral Months Days Hours Director 02-09-1947 62 Country) MD 214-44-5764 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 1 YYes 2 No BALTIMORE MD 28a-f show notified at once. death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 3610 FAIRVIEW AVENUE 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 X Yes 2 No
Divorced If Yes, Give Year 1967-1970 1 Yes 2 X No specify: Specify: BLACK after marked other than "natural", c event, the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 injury or other traumatic event, the Medical E MD 21215-0036 **JANITORIAL** U.S.GOVT. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **FORTUNE** SCHEFIELD JANIE M. HARPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APT A, ROANOKE, VA 24017 GREGORY F. SCHEFIELD 1010 HANOVER AVE. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) ▼ Burial 2 Cremation 3 GARRISON FOR. V.A. 12/08/09 OWINGS MILLS, MD Donation 5 Other Specify 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC Signature of Funeral Service License 1701 LAURENS ST., BALTO., MD 21217 mes Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Methadone intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner Couse. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical X AMENDED #1 tending physician a use as the burial -X UNPENDED 23a, 27,28a-f,perm,E g899 1/5/10 TT Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed' No Yes 2 1 V Yes 26 Place of Death (Check only one) 25. Was case referred to medica Be Other; examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 Inpatient 2 this 1 V Yes Na 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2X No Director: Pending unk Fd 11/28/09 Fd 1:20 pm 2 Investigation Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

house

Assistant Medical Examiner 32. Registrar's signature

To the Hospital or Attending Physician: Division of Vital 24 hours after death within 24 hours a To the Fineral I

DHMH 17 Rev 1/2001

OCME 2006

Registra

3

Medical

Suicide

29a. Certifier 1 (Check only one) 2

Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

X Could not be

determined

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

Baltimore, MD Fairview Ave

November 29, 2009

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38622 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sten DECPON ZOC mma 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Seasons Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Vear) Days Min. Months Hours 1 □ M 2 🗗 F 220-29-0217 90 Yrs May 20, 1919 Jamaica Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Baltimore Randallstown 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 4219 Herrera Court 21133 Jamaica 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married **Black** 1 ☐ Yes 2 No Specify. Specify 3 → Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephen McFarlane Lydia Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Morrison Daughter 4219 Herrera Court; Randallstown, MD 21133 20b. Place of Disposition (Name of cometery, crematory or other place)
HOLY Family 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/12/09 Randallstown, MD 4 Donation 5 Dother (Specify) Church Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signa re of Firmeral Service Lice Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final VEGRA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to or as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Ye a Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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MD

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It e Medic≡l Examiner must be notified at

72 hours after

within

d 2 should be filed within the and Mental Hygiene.
7 is marked other than "r

permit. Pages 1 and 2
Department of Health ai
important: if item 27 is any injury or any

Baltimore, Maryland 21215-0036

attending physician for use as the burial certificate be The law requires that the death P.0. signed by the a of Vital Records, peen page 2 s has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division

Examiner Physician/Medical ð Completed Be ၉ Certification:

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

24a. Was an autopsy performed 1 ☐ Yes eo, Place of D. t. hec. n. e. 4

24b. Were autopsy findings available prior to completion of cause of death? 2 DNo 1 TYes

25. Was case referred to medical
examiner?
1 ☐ Yes 21X No
27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28h. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other

28d. Describe how injury occurred

5 Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Other (Specify)

29a. Certifier

Natural 2 Accident

3 ☐ Suicide

4 Homicide

30. Name and address of

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title person who completed cause of death (Item 23a) (Type, Print)

29c. License number

4 Nursing Home

29d. Date signed (Month, Day, Year)

State

Registrar

Medical

Q

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D29, 2009 NOVEMBER **Physician** 11:56 AM DANIEL DARMAWAN SATRIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH **BETHESDA** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1**X** M 2□ F 466-47-9153 Director 50 January 4, 1959 Indonesia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, It a Medical Examination and the profitted at Director 1 ☐ Yes 2X No North Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20878 14116 Silent Wood Way United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ∏Yes 2 X No If Yes, Give Year or Dates: 0 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify ģ Specify: 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other than Injury or other traumatic event Software Engineer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yenny Widjaja Adi Nugroho Satria 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14116 Silent Wood Way, North Potomac, Maryland 20878 Kimmy K. Satria / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 5. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2009 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. April M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vento culor Minutes /Medical Due to (or as a consequence of): **Examiner** Years Frontal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2\1\1\0 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined To the Hospour within 24 hours after de To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D68466 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHARINE MCNICOL 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32/Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2009 le sur Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 38624 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 28, 2009 **Physician** 10:20 A M Marie Mable Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 12204 Braxfield Court #8 Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 T Director 84 August 11, 1925 | Maryland 577-30-8900 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r items 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12204 Braxfield Court #8 20852 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23. Iny or other traumatic event, the Madical Examples in the country. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1 □Yes 2 X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Specialist Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Slunt Mable Reeley မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Philip D. Brasier 12411 Braxfield Court #13, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 20a. Method of Disposition Date December 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 2009 4 Donation 5 Dother (Specify) Cemeterv 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Liceris Rockville, Inc. 300 Rockville, Maryland 300 West Montgomery Avenue and 20850 M01498 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of) Examiner Smoker in Past Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been significate page 2 should b Lung Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumonectomy autopsy performed certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.
he Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 30, 2009 D20367 Luca, M. D. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, Maryland 20850 Joe/1 P. Kalman, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0.3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 7 Per In, 8398, 12/04/09dhb 38625 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ 6,10 M WITO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEI Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Days Min. Months Hours 89 **Director** AUG 18 215.05.3204 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Directo 1 Yes X No ANNE ARUNDEL GLEN BURNIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14 9th AVE. NE 21061 USA er than "natural", or items the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No <u>Ş</u> Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. WHITE 3 ₩ Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MACHINE OPERATOR LAUNDRY COMPANY other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ JAMES E. McINTYRE ANITA SEWARD permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 3922 FEDERAL HILL RD., JARRETTSVILLE, MD 21084 NAOMI HASTINGS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, DAVIDSONVILLE, MD 4 Donation 5 Other (Specify) HOLLOWS CHURCH CEM. DEC. 5. 2009 . Signature of Funeral S. rvio FINK FUNERAL HOME, P.A. CRECORX 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 FINK M01148 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Enter the or heart fai shoc Immediate Gause (Final disease or condition Onset and Death Physician/ younder Medical resulting in death) as a consequence of) Examiner batas Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown sate has been signed by the page 2 should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown

Completed by Be မ Certificate:

25. Was case referred to medical examiner?

24a. Was an autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury 1 🗺 Natural 5 Pending 2 No

Investigation Accident 6 Could not be Suicide 4 Homicide determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗍 only one 29b. Signature and title of

29c. License number

09

28f. Location (Street and Number or Rural Route Number,

BAltimore Washington Med Ctr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n o ma

filed (Month, Day, Year) 0 2009 Registrar's Signature

Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h

funeral director,

completed filled in by the

6

State

Registrar

within 2

Medical

29a. Certifier

(Check

State Registrar OLD

COURT RD.

RANDAUSTOWN, MD 21/33

30. Name and ad rest of person who completed cause of death (Item 23a) (Type, Print)

M.D.

MURTUZA ALMED.

31. Date filed (Month, Day, Year)

5401

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** SYLVI A SILVER NOVEMBER 2009 1805 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RAMDALLSTONA BALTIMORE HUSPITAL NORT HWEST 8. Date of Birth (Month Day Year) 05-29-1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2🕇 F Months Days Hours 216-16-2821 86 Yrs MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment and the notified at once. 1 □Yes 2 No Director MD BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 RISES COURT 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: ģ WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOWENTHAL KIRSCH MICHAEL SHIRLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 PHEASANT WOOD COURT, PARKTON, MD 21120 JEFFREY SILVER/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH BETH ISRAEL 12-02-2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovas weles acciden /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2. No 1 ☐ Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day, Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A investigation death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours to To the Funeral I 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 hovenber D0059736 Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FITZPATRICK HOSPITAL OLD WEST ROND WORTH WEST 5401 DEBORAH MATJON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

			For State	State of M	larylan		artment of H tificate of D		ınd Ment		20	ng	38628
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	incate of D	eaur	2 0	Reg ate of Death	g. No. L U	0)	
	Physicia Medio		CATHLEEN VIRGINA SE							onth Wembe	128 2	ear	3. Time of Death
	Examin /	ier	4a. Facility Name (if not institution, Bel Air Hea		ı ·		4b. City, Town, or	Location of	Death		4c. County of	-	å
	Funeral Director		11.0.0			st birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (M	ate of Birth Ionth, Day, Yo	ear)	J. Birthpla	ice (State or Foreign
		_	Usual Residence of Decedent 10a. State 10b. County		10a Citu	, Town or Loc			APF	23, 1	<u> </u>	-	IMORE, MD
	Marylan 8a-f sh tified a	Director	MD HARFORD) -	1	BEL AIR	cation					100	d. Inside City Limits 1 ☐ Yes 2XX No
	h the had a or 2 be no	al Di	10e. Street and Number			DEL AIR	10f. Zip Code			10	g. Citizen of Wh	at Country	y?
	ms 23 must	Funeral	410 E. MACPHAIL RD.			le and	210				USA		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u></u> ≥	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒️∭Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Villed Yes, Give Year or Dates.		If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2XX No	, Mexican, I	in? (Specify Ye Puerto Rican,	es or No- etc.)	14. Race - Black, Specify:	American White, etc WHIT	
15-0	72 hou n "natı 1edica	Completed	15. Decedent (Specify only highes	t's Education it grade completed)		(Give k	ent's Usual Occupa	tion iring most o	of working	16	6b. Kind of Busin	ness Indu	stry
212	within giene. ier thai	Con	Elementary/Seconday (0-12) n/a	College (1-4 or !	5+)		O NOT use retired) PROTOTYPE AS	SEMBLE	R	ŀ	WESTING	HOUSE	
and	oe filed ntal Hy ced oth	To Be	17. Father's Name (First, Middle, La	ast)						Middle, Mai	iden Surname)		
aryl	nould the lind Me s mark		WILLIAM H. KIRBY 19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street ar		or Bural Boute		ty or Town State	e Zin Coo	∀ a)
Σ,	ind 2 si lealth a im 27 i		JUANITA L. BENNETT	DAUGHT	ΓER		REDSTONE RD				087	o, <u>L</u> ip 000	
Baltimore, Maryland 21215-0036	. Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☑ Yourial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from State	ce	metery, crem	sition (Name of latory or other place CEMETERY		Date C 4, 200	- 1	c. Location - Ci	•	•
Bal	permit Depar Impor any in once,		21. Signatu e of Funeral Service V	1	M01148	FI	Name and Address	HOME. 1	P.A.				
	nysician/ Medical			emplications that caused	the death.	. Do not ente	6 CRAIN HWY r the mode of dying, M a SS	such as ca	CLEN BUR ardiac or respi	ratory arrest,	21061	In JO	pproximate iterval Between onset and Death
ب	Examiner			Due to (or as	a conseque	ence of):						U	
-	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a conseque	consequence of):							
	cate be executed physician and the burial-transit	l Exa	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):					 .	+	
200	cate be physici the bu	edical		d								+	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date o		ay Year
ds, P.O	luires that the signed by all the deta	ed by PI	Part II. Other significant condition	s contributing to death b	ut not resul	lting in the ur	derlying cause give	n in Part I.	23		co use contribu		cause of death?
Recor	The law req ate has bee page 2 sho	Completed	Del Al	ression						4a. Was an autopsy performed ☐ Yes 2	d? prior	r to comp	findings available letion of cause of
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:					(Check only o		3 110		
<u>></u>	Phys r this c	은	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatie		R/Outpatient	3 DOA Other:	4 KM Nurs			e 6 🗆 Other (S	(pecify)	
ono	ending eath. or: Afte he fune	Certificate:	1 Natural 5 □ Pending 2 □ Accident Investiga 3 □ Suicide 6 □ Could no	(Month, Day	(, Year)	injury	work?	n es 2□N	1	scribe now i	njury occurred		
Divisi	al or Att s after d il Direct ed in by t		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At hom . (Specify)	ne, farm, stree	et, factory, office		28f. Lo Cit	cation (Stree by or Town, S	t and Number of tate)	r Rural Ro	ute Number,
	he Hospit iin 24 hour he Funera ipleted fille	Medical	(Uneck 2 L. Medical Exa	Physician: To the best of aminer: On the basis of extended the basis of extended the basis of extended the basis of the ba	camination a	and/or investig	ation, in my opinion	death occu	irred at the time	e date and n	lace and due to	the causel	(s) and manner stated.
	Vith		29b. Signature and title of certifier	1.5.			29c. License n	umber			Date signed (M	on <i>th, D</i> ay	
	12	- 1	30. Name and address of person whe STILPI KHOS	no completed cause of de	HAY	S ST	#102, B	ELA	IR, M	D 2	1014		
H	Stat Registra	e ir	31. Date filed (Month, Day, Year)	009 3 Registra	r's Signatui	te par	Kad				•		

Spacek, Cattleen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 18 & 19a, per Fh g898 12/8/09 TT
State of Markland Department of Health and Mental Hygiene

			State of Maryland / Departmen 1 - State Cartificat Cartificat		, 0		0000
			1. Decedent's Name (First, Middle, Last)	e of Death	Reg. 2. Date of Death	No.2009	38629 3. Time of Death
	Physici /Medic		Diane Evelyn Touche		Month	Day Year 2009	3:18 a ^M
	Examir		205	Town, or Location of Death		4c. County of Death	
	Funeral	-	305 Tall Pines Court Unit C 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under	Abingdon 1 Year If Under 24 Hrs. ,	8. Date of Birth (Month, Day, Ye	Harford 9. Birtho	lace (State or Foreign
	Director		212–48–0778 1 M 2 XF 63 Yrs. Months	Days Hours Min.	(Month, Day, Ye 0/19/194)	6 Coun	lace (State or Foreign try) MD
land	ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
Mary	a-f sh	ctor	MD Harford Abingdo	n			1 □Yes 2 No
vith the	or 28 be not	Director	10e. Street and Number 305 Tall Pines Court Unit C 2	Code 21009	10g.	Citizen of What Count	try?
leath v	ns 23a must	Funeral			cify Yes or No-	14. Race - America	an Indian
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminer must be notified at once.		Armed Forces? If Yes, spec 1 Never Married 2 Married If Yes 2 No If Yes, Give 1 Yes 2 3 Widowed 4 Divorced Year or Dates:	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R 2 X No <i>Specify:</i>	lican, etc.)	Black, White, e	tc.
15-0	"natu	letec	life DO NOT us	rk done during most of working	g 16b	. Kind of Business/Ind	ustry
212 within	r than	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) 12 Manao	,		Retail	
nd Se filed	tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, Maid		
rya Pould I	d Men marke matic	ပ္	•				
, Ma	alth an 127 is ertrau		19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address Michelle Christina Touche/ Daughter 305 Tall	(Street and Number or Rural L Pines Court,			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours aft	nent of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 **Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nancemetery, crematory or of Final Journey)	ther place)		. Location - City or Tov	
Balt permit.	Departi Importi any inji once.		Ma:	d Address of Facility ryland Crema Box 1413,	ation So	ervices	203
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	e of dying, such as cardiac or	respiratory arrest,	 	Approximate Interval Between
	ysician /iedical			r Cancer		Ċv	Onset and Death
	aminer		Due to (or as a consequence of);				J
P	ti.	iner	Sequentially list conditions, if any leading to incredible cause. Enter Underlying				
xecute	and Il-trans	Examiner	Cause (Disease or injury that initiated events c				
68760,ct	g physician and s the burial-transit		d				
	ng phy as the	Medical	IF FEMALE:				
ords, P.O. Box requires that the death cer	y the attending p ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (spread)			23d. Date of delive Month	ry Day Year
S, P.	signed by the a	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
ord	s been sig should b	ted t			1 □ Yes	2 No 3 Proba	ably 4 ☐ Unknown
The law	ate has	Completed			24a. Was an autopsy performed 1 \(\sum{Yes}\)	prior to con death?	sy findings available apletion of cause of
Of Vital Physician: 7	certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DO	26. Place of Death (
Phy.	in. : After this certifica : funeral director, p	<u>ان</u> کو	27. Manner of Death 28a. Date of Injury 28b. Time of 28	4 Li Nursing Home	e 5 Pesidence 3d. Describe how in	6 ☐ Other (Specify)
SIO tendin	or: Af	catio	2 Accident Investigation M	1 ☐ Yes 2 ☐ No			
DIVISION I or Attending	Direct Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 28	Bf. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
e Hospita	Within 24 hous after locarin. To the Funeral Director: After the completely filled in by the funeral.	ledical C	29a. Certifier (Checkonly one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred: 2 ☐ Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, ar in my opinion, death occurred	nd due to the caused at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To th	To th comp	Me	29b. Signature and title of certifier 29c.	License number		Date signed (Month, D	
		-		0 433-10	100	vember 30	, 2001
	10			#208, Bak	fivere 1	nd 212	37
	Stat Registra	e	31. Date filed (Month, Day Year) DEC 0 3 2009 32. Registrar's Signature.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year OSEPH HOMAS 2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 1**X**M 2□ F Months Days Hours Min. 220-20-3357 79 04-09-1930 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 LYNDHURST ST. 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 LABORER SCHMIDTS BAKERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOSEPH** THOMAS ROSE HOWARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 LYNDHURST ST., BALTO., MD 21229 CATHERINE WRIGHT/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PK 4 ☐ Donation 5 ☐ Other (Specify) 12/07/09 BALTIMORE, MD 22. Name and Address of Facility JAMES A.MORTON & SONS F.H., INC Signatur eral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio myopAThy disease or condition resulting in death) Schemic Due to (or as a consequence of) SEPSIS Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Liver IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 🗆 Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~ ~ ~ ~ one any injury or other traumatic event.

/Medical

10a. State

MD

Director

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriest-termond Division of Vital Records, P.O. Box 68760.

Examiner Physician/Medical þ Completed Be Certification: To Medical

Part II. Other signi	icant conditions of	ontributing to deal	n but not res	ulting in the und	erlying o	ause given i	n Part I.		23e. Did tobacco us	se contri	bute to the caus	e of death?
Congest	Tive 1	eart F		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknow								
									24a. Was an autopsy performed? 1 ∐Yes 2 ☑ No	pr de	Vere autopsy find rior to completion eath? □Yes 2 ☑No	n of cause of
25. Was case refer	red to medical					26	S. Place of Dea	th (C	Check only one)	•		
examiner? 1 ☐ Yes 2 🗹	No	Hospital:	atient 2 🗆	ER/Outpatient	3 🗆 D0	OA Other:	4 Nursing H	lome	5 ☐ Residence 6	Othe	or (Specify)	
27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	1	Injury <i>Day, Year)</i>	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes	2 □No	280	I. Describe how injury	occurre	bd	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of building	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			Number,
29a, Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	ysician: To the be	s of examina	owledge, death o ation and/or inve	occurred	at the time, n, in my opini	date and place on, death occu	e, and	d due to the cause(s) at the time, date and	and mar place, a	nner as stated, nd due to the ca	use(s)

29c. License number

3

State Registrar

ISON

29d. Date signed (Month, Day, Year) 1700011558

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,

225 Greene 32. Registraris Signature

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner mans the second office.

Baltimore, Maryland 21215-0036

sician and burial-trans physician s the burial attending p for use as t signed by the a page director, After this funeral within 24 hours after death

To the Funeral Director;
completely filled in by the f

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/Medical Completed by Be Certification: To

9 Unknown 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

29a. Certi r

(C - ck only

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending investigation 6 ☐ Could not be determined

1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 00060560

29d. Date signed (Month, Day, Year) NOVEMBER 30, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and address of person who a mpleted cause of death (Item 23a) (Type, Print)

HILADELPHA FOAD #208, BALTINWAY, MS 9106 PM

31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 38632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:00 R Joseph W. Tarr DEC 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ST. AGNES HOSPZIAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 4, 1 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Hours Min. 1926 220-18-5530 83 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 10b. County 1 ☐ Yes 2X No Director MD Baltimore Catonsville death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Stonewall Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: White δ Specify: 3 ₩ Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "y any injury or other traumatic event, if what pines of other process." City roads and Elementary/Secondary (0-12) College (1-4or 5+) highways Project Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Wadsworth Tarr Elizabeth Sinclair Will ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Harbinger Drive; Lewes, DE Kathleen Quinby Daughter 19958 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 12/5/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signal le of Saneral Service Licens 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) 7 DAYS /Medical Due to (or as a consequence of): Examiner RESPIRATORY INSUFFICIENCY Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a consequence of SHOCK Hospital or Attending Physician: The law requires that the death certificate be execu attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy performed? /es 2 No certificate 1 ☐ Yes of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 □Yes 2 🖼 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 2000 ASZ43 85284350 DEC 2 OXI 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) J. OWENS 2/229 2900 CATON ANE BALTEMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2009 Margaret Ann Tait 4:14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11506 Hitching Post Lane Rockville Montgomery 8. Date of Birth Month, Day, Year May 12, 1929 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 K 80 Virginia Director 229-38-6671 Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland | Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11506 Hitching Post Lane 20852 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ross D. Campbell Ruth Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher F. Tait/Son 6270 Winters Lane, Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery
Crematorium, Inc Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December Bethesda, Maryland Pumphrey Funeral Home/ Montgomery Avenue 2009 22. Name and Address of Facility Robert Rockville, Inc. 300 W. Rockville, Maryland 20 21. Signature of Funeral Service Lipens 300 West and 2085 hor M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer Medica resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Yes 2 X No 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🛣 No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☒ Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a edical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51616

State Registrar

20

32. Registrar's Signature

Nelson Kalil, 5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) **TEC 0 3 2009**

November 30, 2009

State of Maryland / Department of Health and Mental Hygiene, G898 12/3/09 cambificate of Death 38634 1 StateAmend #26 Per MD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 29, Michael A. 2009 Vecero November 3:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1205 Union Avenue N/A Baltimore 8. Date of Birth (Month, Day,)
Dec. 17, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** . 1<u>956</u> Min. Months Days Hours 1**XX**M 2□ F 200-46-1205 52 Director Wyomino Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at XXYes 2 ☐ No Director Maryland N/A Baltimore the 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Items 23a or 3 1205 Union Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 72 hours after 1 Never Married 2 ☐ Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CXNo Specify. \$ Specify: White 3 Widowed 4 Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Salad Bar Manager Supermarket permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If Item 27 is marked other I any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vecero Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Helm Partner 1205 Union Avenue, Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Atlantic Crematory 12/01/2009 Glen Burnie, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 21. Signature of Funeral Service/Ucensee 3631 Falls Road, Baltimore, Maryland 23a. art1. Effet the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final ACQUIRED **Physician** DEPICIENCY IMMUNE disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Dav 5 Other (specify) ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No =2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: A letely filled in by the fu death. 1 □Yes 2 □No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier Medical 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and tible of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person ho completed cause of death (Item 23a) (Type, Print) 3333 SPERLING, CAL BALTO ST 32. Registrar 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

			For State Registrar		State of Ma	arylanu / i	Certific	cate of D	eath		Reg. No.	109	38635
1	Physicia Medio		1. Decedent's Nam		argaret Ela	ine Wh	eeler			2. Date of De Month	Day Nov 29, 200	Year 09	3. Time of Death 3:30 PM
	Examin		4a. Facility Name (if		e street and number)				Location of Deatl	· ·			imoro
	Funeral		5. Social Security N	lumber 6.5	Hospice Center	(In yrs. last birt			If Under 24 Hrs.	8. Date of Bir			
	Director		215-28-	-33/4	1 □ M 2 XF	77	Yrs. Mo	nths Days	Hours Min.	(Month, Da	y, Year) 21, 1931	Coun	MD MD
	and show at	ō	Usual Residence of 10a. State	10b. County		10c. City, Town	n or Location	n		-		1	0d. Inside City Limits
	Maryla 28a-f s otified	rect	MD Howard Woodstock							ck			1 🗆 Yes 2 💢 No
	th the 3a or 2 t be no	Funeral Director	10e. Street and Nur				10	of. Zip Code			10g. Citizen of		
	ath wi	nue	10801 Enf	field Dr.	12. Was Decedent Ev	ver in U.S.	13. Was [Decedent of His	21163 panic Origin? (St	pecify Yes or No-	14 Bac	U.S.	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F		ried 2 Married	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.			specify Cuban Yes 2 No	panic Origin? (Sp., Mexican, Puert Specify:	o Rican, etc.)	Blac	ck, White,	
5-0	2 hour "natu edical	plet	(Spe	15. Decedent's l		16a.	Decedent's (Give kind o	Usual Occupat	tion uring most of wor	kina	16b. Kind of B	usiness Inc	dustry
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ylar	ld be f Menta arked atic ev	잍			Richard Mod	oney				Ε	lizabeth W	/eber	
Mar	2 should I th and Me 27 is marl traumati		19a. Informant's Na	. ,	,	19b					er, City or Town, S	State, Zip C	Code)
	Healt Healt tem 2		Brian Wh 20a. Method of Disp		-	20b. Place of			. Sykesville	e, MD 2178	20c. Location	- City or To	wn. State
0 p	Page 1 nent of ant: If i		Burial 2 4 Donation	☐ Cremation 3 ☐ 5 ☐ Other (Spec	Removal from State			y or other place, Memorial F	·	c 03, 2009		-	Maryland
3,30 p Baltimore,	permit. Page Department Important: If any injury or		21. Signature of Fu	ner Servici Licer	See Plate	10179	22. Nan	ne and Address Slack Fu 3871 Old		P.A.	City. MD 210	143	
			23a. Part 1. Enter t	the disease, or con	plications that caused tone cause on each line.	the death. Do n	ot enter the					743	Approximate Interval Between
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ď.	Medical Examiner		resulting in death)	ſ	Due to (or as a	c sequalice o	of):						0
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=Wa	icate be executed physician and is the burial-transit	alE	resulting in death) !	Last	Due to (or as a	consequence of	of):						
3760	ifficate to ng physias the I	ledic			d					···-			
89 x	ending r use a	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outcome of		3 🗆 Ecto	opic pregnancy			23d. Da	te of delive	ry
alre	e deatl the att hed fo	Completed by Physician/Medical Examiner	in the past 12 r 1 Yes 2 9 Unknown	Z No	4 ☐ Pregnant at t 9 ☐ Unknown			er (specify)			Mo	onth	Day Year
2a.	that the	y Ph	Part II. Other signif	ficant conditions	contributing to death but	t not resulting i	n the underly	ying cause give	n in Part I.	23e. Did to	obacco use conti	ribute to the	e cause of death?
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Recor	aw rec las bee 2 sho	nplei								24a. Was	osv	prior to con	sy findings available inpletion of cause of
Wheele	r. The licate h	Con	05.14/							1 🗆 Yes		death? 1 🗌 Yes	2 □ No
H/e	rsiciar s certif directo	To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☑		Hospital:	nt 2 🗆 ER/Ou	tootiont 2	Other	e of Death (Chec		dence 6 2 Othe	/0:6-\	Has aire
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ion	tendin leath. cor: Af the fu	Certificate:	2 Accident 3 Suicide	5 ☐ Pending Investigatio 6 ☐ Could not t	n		M	1 □ Y	es 2□No				
Division	l or At after o Direct	Cert	4 Homicide	determined			rm, street, fa	actory, office		28f. Location (S City or Tow	Street and Numbe n, State)	er or Rural i	Route Number,
Δ	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2	☐ Medical Exam	rsician: To the best of m niner: On the basis of exa	amination and/o	r investigatio	n, in my opinion	, death occurred a	at the time, date a	ind place, and due	e to the cau	se(s) and manner stated.
	To the within 2 To the Comple		only one) 3 29b. Signature and		se Practioner: To the be	est of my knowl	edge, death	occurred at the t 29c. License r			e cause(s) and ma 29d. Date signed		
	- > - 0		Ma	in Su	t, CRNP			RIYA			Decemb		
	G		A	_	completed cause of dea	ath (Item 23a) (1	Type, Print)	6					
	7		Maria 31. Date filed (Mont)	n Grant	32. Registrar's	· (hal	cs St	Tow	son, N	10 213	204		
	Stat Registra	·	DEC	0 3 2009	Oz. negistrar	Signature	ALCO!						

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AMEND TTEM#29c perDVR, G898, 12/16/09, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year WAYNE Month WOODZELLE 11:45 AM 26 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) BALTIMORE N/A UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 🔀 M 2 🗆 F 216-34-2372 75 August 22,1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🕅 No Maryland Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 8302 Overmont Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 3 yr's Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Η. Woodzelle Mildred Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5708 Willowton Avenue Baltimore, MD MildredWoodzelle - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp 11/30/09 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21214 21. Signature of Funeral Service Licenses X Leonard J. Ruck, Inc. 5305 Harford Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MELANOMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Physician /Medical **Examiner** #29 P.O. Box 68760, certificate Division of Vital

burial-tran attending physician for use as the burial ed by the a detached f cate has been signated page 2 should b al or Attending Physician: T s after death.
It Director; After this certificat ad in by the funeral director, pa within 24 hours a To the Funeral L

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanding and use by nutflied at

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is marked other than "natural", or itel

1 and 2 s Health ar

Pages 1

Department of Health Important: If item 27 any injury or other tr.

Saltimore, Maryland 21215-0036

State Registrar KHALILZADEH

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE MD ZIZCI

P24418

NOVEMBER 26, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. GREENE ST TOURAT

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

32. Registrar's Signature

and manner stated

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM#ZIPETFH, C898, 12/3/09, WS

AMEND TIEM#ZIPETFH, C898, 12/3/09, WS

amend items State of Maryland 7 Department of Health and Mental Hygiene 2 0 0 9

Certificate of Death

Reg. No. 38637 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 29, 2009 7:20 P M November Barbara J. Winslow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Nursing Home Rockville | Honder 1 Year | Hours | Min. | April 16, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 94 384-22-3863 Yrs. Michigan Usuat Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. tnside City Limits Montgomery Rockville 1 ☐ Yes 2X No Director California 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 303 Adclare Road 95648 20850 United States 504 Sawmill Court Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: δ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation

16a bind of work done during most of working Completed 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) Cotlege (1-4or 5+) Elementary/Secondary (0-12) Musician Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Winslow ဂ Julia Tygh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Susan Ernst / Niece</u> 504 Sawmill Court, Lincoln, California 95648 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Fungfal Service, Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Hypertensive Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe Dementia Due to (or as a consequence of) Examine Respirator Failure Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed burial-tran attending physic signed by the a Division of Vital Records, P.O. should I funeral director, After Attending efter death.

Director: Aft filled in by 5 within 24 hours e To the Funeral I To the Hospital

Funeral

Director

ir than "natural", or items 23a or 28a-f ehor the Modical Exercines result by notified at

other

5 permit. Page Depertment of Important: If any injury or once.

Physician

/Medical

Examiner

Pages 1 and 2 should be filment of Health and Mental Hiant: If item 27 is marked ot

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filed within 72 hours after

Baltimore, Maryland 21215-0036

State

TV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUSUPH November 30, 2009 D0047330 Swowins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 50 West Edmonston Drive, Rockville, Maryland 20852 Thomas V. Joseph,

29a. Certifier

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Drucie Angela Arthur 4.42 AM NOVant Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Beltimore N/Abuttimork 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Hours (Month, Day, Country) Maryland Director 214-62-7349 55 1954 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f slinjury or other traumatic event, the Medical Examiner must be notified. Baltimore N/A ty⊡ Yes 2 ☐ No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21216 3706 Chesholm Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, et Completed by 1 Never Married 2 Married Black If Yes, Give Year or Dates 1 ☐ Yes 21 ☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7. Health and Mental Hygiene. Iem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Odyssy Modeling Model Years Agéncy Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Drucie Palmer <u>Robert Arthur</u> 19a. Informant's Name/Relationship (Type, Print) Jennifer Goffigan/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 218 626 Dumbarton Avenue Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13/09 Baltimore, Maryland Greenmount Cemetery 22. Name and Address of FacilityChatman-Harris Funeral Home 21. Signature of Funeral Service Licen 5240 Reisterstown Rd Baltimore, MD 21215 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart facture. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Enysician. a Motastatic Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examiner Due to (or as a consequence of, day, leading to immedia cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Hospital or Attending Physician: The law requires that the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner?

1 Yes 2 No the fune al director, Be 26. Place of Death (Check only one) 10 Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate; 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? After 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation a er death Director: / 6 Could not be within 24 hours a er de To the Funeral Directo completed filled i by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 L 3 L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) RES 000

State Registrar nerson who

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32. Registrar's Signature

Bobby
31. Date filed (Mod)

3

opleted cause of death (Item 23a) (Type, Print) 2701 W Belve DENE Dre, Balt, mare, MD

Sinai Hospital of Bultimen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1- State Registrar amend 28a-f per Dr. g898 12/4/109atektaf Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Guadalupe 00 2009 Maria 300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner General Hospita Howard County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours **Director** Mayland <u>infa</u>nt Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2√ No Directo MD Howard COlumbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21046 USA 6801 Carlinda Avenue by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married 21215-0036 1X Yes 2 □ No Specify: mexican Specify: hispanic 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene, : If Item 27 is marked other than ' or other traumatic event, 1 m Me Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Manuel Arroyo Adriana Arroyo ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5755 Cedar Lane Columbia, MD 21044 Howard County General Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any Injury or once. 4□Donation 5 ☑Other (Specify) in state 21. Signatur Luneral Service Lice 22. Name and Address of Facility Board 655 W. Baltimore Street Wade, Wirector . im Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prematunh /Medical Due to (or as a consequence of): 1 hr 48 min Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as tha burlal-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □

No 24a. Was an autopsy perforn 1 ☐Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: NA Division Natural 2 Accident 5 Pending investigation 1 □Yes 2 □YN MA 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) olumbia MD State 4 MEC Registrar

DHMH 17 Rev 1/2001

			For per Dr. State of Maryland / Department of Health and amend 28a-f g898 12/4/09 Cachificate of Death	Mental Hy	rgiene 0 0	9 38640					
			1. Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death					
	Physici		Juan Polblo Arroyo	Month ()		009 1235 M					
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County of	Death					
	LXuIIII		Howard County General Hospital Columb	ia	How	and County					
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs		rth 9	Birthplace (State or Foreign Country)					
	Director		infant 1 M 2 □ F Yrs. Months Days Hours Min.	3 00	26,2009	maryland					
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	anyla shov	7				1. Yes 2 No					
	he M	ect	MD Howard County Columbia		10g. Citizen of Wh						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at once.	Funeral Director	10e. Street and Number Carlinda XVE. 10f. Zip Code 21046		M. S						
	r dea	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Black,	American Indian, White, etc.					
36	or i	by F	1 🕅 Never Married 2 ☐ Married 1 ☐ Yes 2 🗗 No ☐ 🚬 /	lex icour	Specify:	Hispanic					
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Maryland	nd M mar	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ri								
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စ်	s 1 al f He item othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - Ci	ty or Town, State					
e E	Page ent o nt: If ry or		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state								
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Division	Atter r dear	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,							
Ď	al or after Direction	erti	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)						
11	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1. V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the	e cause(s) and man	ner as stated.					
	n 24 n 24 ne Fu	Medical	(Check only one) 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time	, date and place, an	d due to the cause(s)					
	To the transfer of the transfe	Ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)					
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			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10.710 Charter Dr. Surte 200 Colum			0.417					
				nora,	MD 21	1044					
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c. per DVR g898 12/4/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2:36 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 to NIVERS: 100 Social Security Number univer 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Year) 2009 Min. 1 X M 2 □ F Months Days Hours infant 04 14, Director Nov Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Examiner must be notified at Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 I SE 4547 Finney Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: black ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) infant infant infant 1 and 2 should be filed wi Health and Mental Hygier tem 27 is marked other th unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shanae Adams မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other troops. University of MD Medical Ctr 22 S. Greene Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Nother (Specify) in State Rona Id State Andress Factor 655 W. Baltimore Street icen was ,/Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** xtrene disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (unas a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 X No icate has been siç ; page 2 should b 3 Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 2 □ No 1 ☐ Yes 2 No Physiclan: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number **RES000**

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29

32. Registrar's Signature

ma

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CHARLES RICHARD BELL 2009 5:10A DEC /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MANOR CARE -RUXTON BALTIMORE RUXTON f Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7 Age (In vrs last hirthday) 6 Sex **Funeral** Months Days Hours Min 1**X**XM 2□ F 201-28-6409 1-1-1933 PA. Director 76 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Baltimore County 1 ☐ Yes 2XXXVo Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21152 USA 14206 Dove Creek Way Unit 02 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

XID Yes 2 Do If Yes, Give 1956-58 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√CXNo Specify Specify: <u>Ş</u> White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) Mortgage Banker Capital Mortgage Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Lord Gibson Charles Bell P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 and Department of Health at Important: If Item 27 Is any injury or other trau 14206 Dove Creek Way Unit 02 Sparks, Md. 21152 Sonia Bell (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem.12-5-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Honme 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee Llother Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise or complications that caused the deall. En not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dementa Storge **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mustensia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Accident erobro viscolore attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed After this certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 MedicaLExaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

441 State

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Hospital or Attending 24 hours after death.

hours after death

within 72

Baltimore, Maryland 21215-0036

Uharles (アピリトロリン) Division of Vital Records, P.O. Box 68760

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

HIRMARA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and ad ass of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ORIGINAL

7505

29c. License number

29d. Date signed (Month, Day, Year)

osler Drive, such 509. Talvson, ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mar	,	-	ificate of L			Reg. No	2009	38643
Г	Physicia	an	1. Decedent's Name (First, Middle, Last						2. Date of D Month	eath Da	ay Year	3. Time of Death
1	/Medic	al	Marie	J.	Brown		4h City Toyan or	Location of Doot	Nov. 2		009	7:42 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville						11	4c. County of Death Montgomery		
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of B	irth	9. Bir	thplace (State or Foreign
	Director		205-18-8934	□м 2 X □F 8	4	Yrs.	Wioritis Days	TIOUIS WIII.	Dec. 1	, 19	0 1	nnsylvania
	land ow	by Funeral Direc	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Towr	n or Loca	ation					10d. Inside City Limits
	Mary a-f sho fied a		Maryland Anne Aru	nde1	Sever	n						1 X Yes 2 ☐ No
	th the or 28s		10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?
	ath wi		7816 Poplar Grove				21144			U.S		
	ter de		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ▼ No		13. Wa	as Decedent of Hi res, specify Cuba	ispanic Origin? (S n, Mexican, Puer	specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, It. W. dical Examiner must be notified at		3 ♥ Widowed 4 □ Divorced Year or Dates:			1 □Yes 2 📉 No Specity:					Specify: White	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a.	. Decede	nt's Usual Occupa	ation during most of wor	rkina	16b. l	(ind of Business	Industry
7	vithin ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)			o NOT use retired Reeper)			aal Cama	
0	filed v Hygie other i	e Co	12 17. Father's Name (First, Middle, Last)		1	BOOKE	Keeper	18. Mother's Nar	ne (First, Middle		oal Comj n Surname)	Dany
an	lid be fental rked c	To Be	George P. Boyder					Eva Ch	ura			
ary	2 should be f h and Mental I is marked of raumatic eve	_	19a. Informant's Name/Relationship (T)	/pe. Print)	19b	. Mailing	Address (Street a	and Number or Ri	ural Route Num	ber, City	or Town, State,	Zip Code)
., ∑	and 2 lealth m 27 her tr		Jean M. Hulet (Day	ıghter)				rove Rd.	-			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mentz Important: If item 27 is marked any injury or other traumatic enone.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ F	Removal from State			tion (Name of tory or other place	i i	Date		ocation - City or	Town, State
	artmel artmant ortant injury		4 ☐ Dorration 5 ☐ Other (Specify)	<u> </u>	Sacred		art Ceme		/1/09		ton, PA	71
Ba	lmpc any any		Duni V	Millian	_			Bon In Fu				18201
		Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
and .	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a									Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	y					
			Sequentially list conditions, Due to or sea consequence of r									
	uted d ansit		Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
ó	e exec an an rial-tra											
68760,	tificate be executed g physician and as the burial-transit	edical		d								
			IF FEMALE:	23c. If yes, outcome of	pregnancy						23d. Date of de	liver
Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/N	250. Was decement pregnant in the past 12 months? 1 \[\text{Live birth} \] 2 \[\text{Fetal death} \] 3 \[\text{Ectopic pregnancy} \] 5 \[\text{Other (specify)} \]							Month		Day Year
<u>Р</u>	by the	hys	9 Unknown	1 Tes 2 PNO 9 I Inknown							-	
	es t igne be c	ρ	Part II. Other significant conditions co								contribute to the cause of death?	
oro G	requir	sted	-						1	Yes 2	Magino 3∐P	robably 4 Unknown
Records,	has b	Completed							24a, Wa	s an opsy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of
_	siclan: The la certificate ha rector, page 2		25. Was case referred to medical		·			00 Diagram	1 □ Yes	2 🔼 N	o 1 ☐ Ye	2 🗷 No
	ysicla is cert directe	o Be	25. Was case referred to medical examiner? 1 Yes 2 No								acify)	
Vital			27. Manner of Death 28a. Date of Injury 1 Natural 28b. Time of Injury Work? 28d. Describe how injury occurred Injury 1 Notice 1 Natural 1 Notice 1								iony)	
n of Vit	ng Ph fter th neral	T:UC					l Work	?	28d. Describe	non ange	-	
sion of Vit	tending Pheath.	cation: T	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year) li	Injury	M 1 □'	yes Yes 2□No	28d. Describe			
Division of Vit	or Attending Phater death. Director: After the in by the funeral	ertification: T	1 Natural 5 ☐ Pending		Year) I	Injury	M 1 □'			(Street a	nd Number or R e)	ural Route Number,
Division of Vit	spital or Attending Phrours after death. neral Director: After th	al Certification: To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Pending investigation 6 Could not be determined	(Month, Day, 1) 28e. Place of Injury building, etc.	y - At home, fa (Specify)	injury irm, stree	M 1 □	Yes 2 □ No	28f. Location City or To	(Street a	s) and manner a	s stated.
Division of	Hospita 4 hours Funeral tely fille		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Pending investigation 6 Could not be determined	(Month, Day, 1) 28e. Place of Injury building, etc.	y - At home, fa (Specify) my knowledge	injury irm, stree	M 1 □	Yes 2 □ No	28f. Location City or To	(Street a	s) and manner a	s stated.
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification: T	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Exam	(Month, Day, 1 28e. Place of Injury building, etc. sician: To the best of Iner: On the basis of e	y - At home, fa (Specify) my knowledge	Injury arm, stree e, death c ad/or inve	M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	res 2 □ No me, date and place pinion, death occurs enumber	28f. Location City or To	(Street a wn, State e cause(e, date ar 29d. D	s) and manner and place, and durate signed (Mon.	s stated. a to the cause(s)
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Injury building, etc. sician: To the best of Iner: On the basis of e and manner state	y - At home, fa (Specify) my knowledge examination and	Injury arm, stree e, death c ad/or inve	M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	res 2 □ No me, date and place pinion, death occurs enumber	28f. Location City or To	(Street a swn, State e cause), date ar	s) and manner and place, and durate signed (Mon.	s stated. a to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16a&b, 18&19a Per FH G899 1/15/2010 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 2,2009 Maurice A. Barrett, Jr. December 0246 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1**X** M 2□ F Director 215-18-8782 86 January 29,1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director Md. Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examlner must be USA 14012 Bardot Street 20853 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. X Yes 2 No If Yes, Give Year or Dates: 1943-1966 filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life POO NOT use retired. Officer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government ene. Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 12 Colonel Air Force h and Mental Hygier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther and 2 should be Thomas Maurice A. Barrett, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois I. Barrett/spouse Department of Health a Important: If item 27 Is any Injury or other trau once. 14012 Bardot St. Rockville, Md. 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington National 1-28-2010 Arlington, Virginia 21. Signature of Funeral Se e Li ensee 22. Name and Address of Facility Schimunek Funeral Home D Drum 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Failure **Physician** /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Congestive Heart Failure burial-trar Due to (or as a consequence of): physician Exacerbation of Chronic Pulmonary Physician/Medical the Obstructive Dilear use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Pleural Effusion 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

Division or Vital Records, ō Hospital within 2 To the

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P.O. Box 68760,

altimore, Maryland 21215-0036

Va

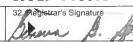
State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier 7

Viny Ganti ,MD





29c. License number

D41162MD

29d. Date signed (Month, Day, Year)

DECEMBER 2, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Murguret 13arten 00:00 01 2000 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore UNIVERSITY SPECIALITY HUSSITAL N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🛛 F Director MARYLAND JUNE 16 1940 213-42-3160 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show be notified 1 ☐ Yes 2 XXVo Director HAVRE DE GRACE MARYLAND HARFORD CO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö or Items 23a 601 N STOKES ST 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify. Specify: BLACK Š 3XWidowed 4 ☐ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENG. HOUSEKEEPER 12th grade HOLIDAY INN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE OSBORNE CATHERINE OSBORNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 N. Stokes St., Havre de Grace, Maryland 21078 Kenneth Barton/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND METRO CREMATORY 12-08-09 21. Signature of Eugeral Sowice Licensee 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. S PHILA. BLVD, ABERDEEN, 2a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Quesh Immediate Cause (Final disease or condition resulting in death) **Physician** Premmania /Medical Due to (or as a consequence of): **Examiner** Responter Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Any otrapic Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy performed certificate ha 1 Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 32. Régistrar's Signatur 17. Régistra

30. Name and address of person who ampleted ceuse of death (Item 23a) (Type, Print)



D61882

12-01-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 1.15PM 00 100 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 136 Sal timore MD enesis seven con ter Imore 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 995 216 66 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No MD. Director Baltimore Parkville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code |United: States 8720 Emge Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: þ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. If Item 27 Is marked other than or other traumatic event, the Me College (1-4or 5+) Disable Disable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be N. Samuel Booth Gene Bukata 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Street Ias Vegas, NV 89179

Date 20c. Location - City or Town, State Ryan Booth 10553 Caveridge 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or West Arundel Crem. Dec. 3,09 Odenton, Maryland ^{22. Name and Address of Facility}Ambrose Funeral Home, INC. 1328 Sulphur spring Rd. Arbutus, MD.21227 21. Si pare Fy eral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MELL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) signed by the aid 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 □ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of s certificate has t lirector, page 2 s death? 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No within 24 hours after death.

To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09 K11380 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Ρ. May Burrows NO 30 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ma Himore SG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-13-1927 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2√xF Months 163-20-9523 82 Pennsylvania **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the tholical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5648 Chelwynd Road 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be file th and Mental H 7 Is marked oth Be Francis Flores Edna Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar 5041 Stone Hill Drive, Ellicott City, MD 21043 Linda Mullens - Daughter permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 k Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Nat'l. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 12-02-09 Baltimore, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature f Funeral Service Licensee MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran The law requires that the death certificate be exec Due to (or as a consequence of): physician 68760 Physician/Medical use as the the attending Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year 4 Pregnant at time of death 5 Other (specify) 1∐Yes 21CNo detached Ö 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate 1 ☐ Yes 2 > No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

3455

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CON

32. Registrar's Signature

			For State Registrar	State	of Marylan	d / Depa <i>Cer</i>	rtment o	of He	aith a eath	ınd M	ental Hygi	ene 0	09	386	48
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)							2. Date of Death Month	Day	Year	3. Time	
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	Examin	er	4a. Facility Name (If not institution,	-	umber)							nty of Death			
			Future Care		T = 4 //		Baltimore If Under 1 Year If Under 24 Hrs. 8, Date of Bit								
	Funeral			6.Sex 1 ☐ M 21 ∑ F	7. Age (In yrs. I	Yrs.		ays	Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cou	place (State intry)	unk
	Director		251-38-3555 Usual Residence of Decedent		79						May 29,	1930	J		
	iand ow	1	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside	City Limits
	Mary	ģ	MD			Balti	more							1 √ Ye	s 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Co	de			10	g. Citizen	of What Cou	intry?	
	h with	0	323 N. Payson	Street				2	1223			USA			
	deat	by Funeral	11. Marital Status un	-	cedent Ever in U.	S. 13.	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto			gin? (Spe	cify Yes or No-				
٥	after or tte	Fu	1 Never Married 2 Marrie		2 🔯 No	1	1 ☐ Yes 2🏋		Specify:	, , , , , , , , , , , , , , , , , , , ,			city: b1		
9500-61212	d within 72 hours after death with the Maryland plane. Then "Insturet", or tterns 23a or 28a-f ehow the Medical Examerer must be collidated.		3 Widowed 4 Divorced	Year or	Dates:										
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Maryland	s 1 and 2 should the thealth and Mentition 27 is marked their traumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip of										p Code)		
	and 2 ealth a n 27 ie		Future Care Sandtown 1000 N. Gilmore Street Baltimore, MD 212										1217		
m	tem item othe		20a. Method of Disposition	- 00		lace of Dispo	sition (Name inatory or othe	of r place))	С	ate 2	Oc. Location	on - City or T	own, State	
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90	ate be executed hysician and the burial-transit	ical E											į		
68/	ficate physics the			d											
Rox	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		1=					23d.	Date of deliv	very	
ň	death e atte id for	Icla	in the past 12 months? 1 Yes 2 No	4☐Preg	birth 2 🗍 Feta anant at time of d]Ectopic pregr] Other (s <i>peci</i>						Month	Day	Year
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Division	for Attendant after deat Director:	Certification:	4 ☐ Homicide determi	buil	ding, etc. (Specif	(y)	001, 1401013, 0	11100			City or Town				
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filed in by the funeral director,	Medical	(Check only 2 Medical I one)	Examiner: On the and ma	basis of examina inner stated.	ition and/or in	vestigation, in	my opi	nion, dea	th occurr	ed at the time, da	ate and pla	ce, and due	to the cause	e(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	Ž	29b. Signature and title of certifier	0	00	10	29c. L	icense	number	010	2	9d. Date si	gned (Month	Day Year	
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			30. Name and address of person	mo completed ca	use of death (Item	n 23a) (Type,	Print)	2	0	10	0	n ind	0 0	120	1 .
785			31. Date filed (Month, Day, Year)	111111)	Registrar's Signa	Shr	xe >1	-	115	UR	unou	77_	1	120	4
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VICTOR BROWN SR.
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Funeral		5. Social Security N	Number unk		7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.								M/DD/YYYY	Foreign		unk	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be .	19a. Informant's N	amo/Pelations	hin (Type Print)		19h	Mailing	Address	/Street	and Numb	er or Ru	ıral Route	Numbe	r, City or Tov	vn. State.	Zip Co	de)
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× 68 h certi tendin use as	U	past 12 month		4 Preg	nant at time of o	death 5	=	ner (Spec	ify)								
Box le death of the atter	Physi	1 Yes 2		J Olik	nown					i- D-		220	Did tob	acco use con	tribute to	the cau	se of death?
Division of Vital Records, P.O. Box 68760, with the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	by P	Part II. Other sign	nificant condi	tions contributing	to death but not	resulting	in the u	nderlying	cause gi	ven in Pa	π 1.						4 Unknown
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Directors. completely filled in by the fi	Medical	29b. Signature an		and manne						e number				29d. Date sig			
	2	230. Signature an	0 1	0000				-30	O.C.I				- 1	Novembe			
		30 Name and ad	dress of perco	n who completed ca	use of death (Ite	em 23a)											
		Carol Allar		ssistant Medica			Penn S	Street, E	Baltimo	ore, MD	2120	1					
S	tate	31. Date filed (Mo	nth, Day, Year		Registrar's Sign	ature											

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year) Registrar DFC 0 4 2009

OCME

09-08417 Robert Brinkley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

obert Brinkley	1- For State State of Maryland / Department of Health and Merital Hygiene Certificate of Death Reg. No. 2009 386
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1.52 brs
/ledical Examiner √	Robert Brink1ey October 30, 2009 14321115 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death
	6633 Chestnut Avenue New Carolton Prince George's
Funeral Director	5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 1. Months Days Hours Min. July 26, 1954 Foreign Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
<u> </u>	MD Prince George's Riverdale
the Maryland an 28a-f show tiffed at once. Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1
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136 thin 72 ho le. than "na edical Ex	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life, DO NOT use retired)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturingury or other traumatic event, the Medical Example of the property or other traumatic event, the Medical Example of the property or other traumatic event, the Medical Example of the property of th	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk
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AD 21 2 should 1 and Me 27 is ma matic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. M.E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State
imo Pages ment of tant: J	4 Donation 5 X Other Specify: in state
Ball permit Depart Impor injury	21. Signature Euner S Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Determine the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.
/Medical ' vaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):
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Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
BOy he death the att hed for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
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of Vital Records, P.C. g. Physician: The law requires that ther this certificate has been signed meral director, page 2 should be det T. D. Be Completed by	24a. Was an autopsy findings available autopsy prior to completion of cause of
Reco The law icate has page 2 s	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical examiner? Least (Check Only Une)
of Vining Physical After this Tuneral dir.	1 V Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
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Division of a Division of with 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Beddical Certification:	2 Accident 3 Suicide 6 Could not be determined (Specify) Single Family 28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6633 Chestnut Avenue, New Carrolton, MD
To the Host within 24 ho To the Fun completely	
F % F %	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 31, 2009
	30. Name and address of person who completed cause of death (Item 23a)
	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	

OCME

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Belis **Physician** Grace Davannah NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General tospital alumbia, County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours NONE Nov 17, Director 27 2009 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1139 Wicomico Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify à 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant of Health and Mental Hygid If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arioty Belis Tanika Belis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard County General Hospital 5755 Cedar Lane Columbia, MD Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Ø Other (Specify) HOSPITAL HOWARD COUNTY GENERAL HOSPIFAL 21. Signature of Funeral Service Sicensee ad Di Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KTREM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ERVIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Records, 1 🗌 Yes 24a. Was an autopsy performe certificate Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No I Director: / d in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Reg. No. 2009

Year

Howard

Black, White, etc.

Maryland

black.

2009

38651

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1√∑Yes 2□No

01:20 1

Amend 29c State of Maryland 7 Department of Health and Mental Hygiene

20c. Location - City or Town, State ്ട്രീൺ Affat ക്രൂണ് Board 655 W. Baltimore Street 23d. Date of delivery Month Day Yea 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 2009 NOV D 64450 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francisco Rojas, MD 6350 Stevens Forest Rd. Suite 105 Columbia, MD 21046 32. Pegistrar's Signature **ORIGINAL**

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

1 - State Registral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 8898 12/4/09 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Delis 4 10+ NOY ZZ:50 17 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner General Howard Howard County Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months NZM 2□ F NONE Yrs Nov 17, 2009 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov Examiner must be notified at 1√ Yes 2 No Directo MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or ury or other traumatic event, I'm Mailcal Examine marties. 21230 USA 1139 Wicomico Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Š Specify: black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 Is marked a any injury or other traumatic events. Tanika Belis Arioty Belis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5755 Cedar Lane Columbia, MD 21044 Howard County General Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HOWARD County General Hospital 5 Other (Specify) HOSP X 194 4 Donation 21. Signature of Funeral Service License Banald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street on Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TREME disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ERVIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) Ö 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours are to the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 D 64450 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francisco Rojas, MD 6350 Stevens Forest Rd. Suite 105 Columbia, MD 21046 32/Registrar's Signature 31. Date filed (Month, Day, Year) State Bark 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23b&d. Per PHY C898 12/04/09 JH State of Maryland / Department of Health and Mental Hygiene 2 0 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:00 p Arthur D. Bradford Nov 29, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Severna Park 112 Earleigh Heights Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐ F Yrs. Director 213-30-0735 Jul 23, 1934 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Experimentment be notified at 1X Yes 2 No Director Severna Park Anne Arundel Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 112 Earleigh Height Road 21146 U.S.A by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 🖬 No Specify: 3 Widowed 4 Divorced Black is marked other than "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) uld be filed within 7 Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Company Cement Finisher 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) Be Herman Bradford Florence Bradford ၉ Pages 1 and 2 should Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Earleigh Height Road Severna Park, Maryland 21146 Dorothy Bradford Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/05/09 Pasadena, Md. Mt. Zion Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence off: Approximate Interval Between Onset and Death **Physician** /Medical Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): the attending physician Completed by Physician/Medical as the I IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 I Inknown signed by Part II<mark>_I Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 4 Unknown 2 🗌 No 3 Probably 1 ☐ Yes been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed yes 2 No this certificate 2 **N**o 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 2 No 1 ☐ Ye € 1 Inpatient 2 ER/Outpatient 3 DOA 5 MResidence 6 □ Other (Specify) Certification: To 28b. Time of 27. Mapher of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ ted cause of death (Item 23a) (Type and address 2002 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

			1 - For State Registrar		,	Ce	rtificate of	Death		Reg. N	~ Z U U	9 30034	
			1. Decedent's Name (First, Mide	fle, Last)						Date of Death Month Day Year 3. Time of Dea			
	Physici /Medio		C	OLLEEN RILEY	CAPI	ZZI				009 Yea	4:55 P M		
- day	Examir		4a. Facility Name (If not institution	on, give street and numbe	r)		4b. City, Town, o	r Location of Deat	h	4	c. County of De	eath	
no de				VAL MEDICAL	CENTE	R	BE				OMERY		
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	th a <i>y, Y</i> ea	9. E	Birthplace (State or Foreign Country)	
	Director		079-48-8827	1019224	55	Yrs.	Yrs. Months Days Hours Min. (Month, Day, Year) Country) Mar. 9, 1954 New Yor						
	and and		Usual Residence of Decedent 10a. State 10b. Count	У	10c. City,	, Town or Lo	cation					10d. Inside City Limits	
	f sho	ō										1 □Yes 2 No	
	the 1	Director	VA Oran 10e. Street and Number	ge	Loc	ust G	10f. Zip Code			10a. (Citizen of What	Country?	
	3a or	Ö	5384 Williams	Flank Court			22508						
	ms 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No		SA 14. Race - Ar	nerican Indian,	
9	or ite	₫	1 ☐ Never Married 2 🙀 Ma	Armed Forces rried 1 □Yes 2₺			If Yes, specify Cub		to Rican, etc.)		Black, Wh		
03	al", c	þ	3 ☐ Widowed 4 ☐ Divorce	d If Yes, Give Year or Dates	:		1 □Yes 2 ☑ No	Specify:			Specify: T	Thite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be motified at	Completed	15. Decede	nt's Education est grade completed)	Į	16a. Dece	dent's Usual Occup kind of work done	ation during most of wor	rkina	16b.	Kind of Busines	ss/Industry	
21	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)	9				
	led w Hygie her tl	ပိ	0			I	lomemaker		/=:		Own Ho	ome	
ıno	be fill	Be	17. Father's Name (First, Middle					18. Mother's Nar	, ,	, Maide	en Surname)		
Ž	ould J Mei narke	ပ္	Charles E. Ri						Grulich				
Maryland	12 sh th and 7 Is n traun		19a. Informant's Name/Relation		1 1	1	ng Address (Street			-			
e, l	1 and Health em 2 ther		Derek Anthony 20a. Method of Disposition	Capizzi-Hus					Date Locu		Location - City	VA 22508	
סר	ages nt of frit		1 ☐ Burial 2 🖾 Cremation		3		sition (Name of matory or other place				•		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Dedical Evantment must be notified at once.		4 □ Donation 5 □ Other (21. Signature of Funeral Service	•	Jol		Cremator	•	14-2009			ove, VA	
Ba	permi Depa Impo any Ir		21. Signature of Funeral Service	Licenson	-		2. Name and Addre					· ·	
			23a. Part 1. Enter the disease, of	or complications that cause	ed the death.						ust Gro	ve, VA 22508 Approximate	
	Discontinuo		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each	line.			3,	, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	u.	PSIS s a conseque	onoo of):							
7	Examiner			Due to (of a	a conseque	erice or).							
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or hijmly that initiated events	b. Due to (or a	s a conseque	ence of):							
	icate be executed physician and the burial-transit	Examiner	cause, Enter Underlying Cause Disease or injury that initiated events	S									
oʻ	an ar rial-tı		resulting in death) Last	Due to (or a	s a conseque	ence of):							
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39	ertifica ing pl	Med	IF FEMALE:										
Вох	eath cer attendin for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth	2 Fetal	death 3[Ectopic pregnanc	ry			23d. Date of o	delivery Day Year	
0.	at the dea by the a tached fo	Physician/	1 ☐ Yes 2 🙀 No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown		eath 5	Other (specify) _				MOHI	Day Teal	
σ.	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Ph	Part II. Other significant condit	ions contributing to death	but not resul	ting in the u	nderlying cause giv	en in Part I	23e Did i	lobacci	o use contribute	to the cause of death?	
Records,	ires t signe d be d	b	artin out or organically out are	iona community to death	but not room	ang in tho a	nderlying dadde giv	on arrairi.				Probably 4 Unknown	
Ö	w requir been s should	Completed											
Rec	has has	Пр							24a. Was		prior 1	autopsy findings available to completion of cause of	
a									1 □ Yes	2,01		es 2 🗆 No	
of Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			oth	or:	ath (Check only o				
	g Physical this leral dir	i.i	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of In		28b. Time o	IL 3 LL DOA	4 LI Nursing F	lome 5 ☐ Resi			pecify)	
Division	를 - 를 늘 를 - 를 들	ţi	1 Matural 5 Pendi 2 Accident invest	ng <i>(Month, E</i> igation	iay, Year)	Injury	f 28c. Injui Wor M 1 🗆	ḱ? Yes 2 □ No			jany		
/isi	Atten r deat ector: by the	fica	3 ☐ Suicide 6 ☐ Could		jury - At hon	ne, farm, str	eet, factory, office					Rural Route Number,	
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	ospital hours uneral		29a. Certifier 1 Certify	ing Physicien: To the bes	t of my know	vledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause	e(s) and manner	as stated.	
χ	1 2 2 1 2 2 1	edical	(Check only 2 Medica	Examiner: On the basis and manners	of examinati	ion and/or in	vestigation, in my	opinion, death occu	urred at the time,	date a	and place, and c	lue to the cause(s)	
v 1	To the within To the comple	Ň	29b. Signature and litle of certifi	er R			29c. Licens	e number	-	29d. [Date signed (Mo	nth, Day, Year)	
			Kylin	nexem	8		0101	240414 (VA)	1	PC	2009	
			30. Name and address of person	who completed dause of	death (Item	23a) (Type,	Print)	NATION	IAL NAVA	L M	EDICAL	CENTER	
			LYNN A. BYAR		SN				SDA MD 2				
	Sta		31. Date filed (Month, Day, Year		trar's Signatu	ire _	backs						
:	Registr 	ar	UE C	4 2009	MAN	p. 19	W CARLES						

State of Maryland / Department of Health and Mental Hygiene 38655 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12, 2009 **Physician** November 10:06 Mattie L. Coleman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's <u>Hyattsville</u> Paint Branch Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Yrs. 90 July 14, 1919 Virginia 579-44-2414 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at 10a, State 10b. County 1 ☐ Yes 2 No Director Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" or the any injury or other traumatic event. 10402 Tulsa Drive 20783 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Domestic Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Sarah Davis Moses Carter ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phyllis O. Brown (Daughter) 10402 Tulsa Dr., Hyattsville, MD 20783 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Little Mine Road 1 Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/09 Spotsylvania, VA Baptist Church 21. Sign Jure of Funeral Service Livensee 22. Name and Address of Facility A.L. Bennett & Son Funeral Home 200 Butternut Dr., Fredericksburg, VA 22408 riem 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Longestive Heart Failure **Physician** o worter /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if only cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify). P.O. I been signed by the s 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ò Alpheimer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No nemia 24a. Was an has autopsy performed? Yes 2 X No page 2 s certificate 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death, investigation al or Attendi s after death. il Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the } 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rante, ou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

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Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No

Reg. No 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Lawrence Crook 10 Month MBER Day 3. Year (2) 04:19A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Peath timore 4b. City, Town, or Location of Death **Examiner** OWSON Saint Joseph Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec . 21, 1930 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. Country)
Fall River, MA Director 014-24-6825 78 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director CT. Litchfield County Litchfield 1 Yes 2 No 10e. Street and Number 10f, Zip Code r items 23a or iner must be r ö 10g. Citizen of What Country? Funeral 06759 United States 5 Hawthorne Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2 No Korear Black, White, etc. 1 Never Married 2 Married ō Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Conflict White "natural". 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Union Carbide Sales permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Suzannah Smith James Vincent Crook (Wife) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1012 Litchfield, CT. 06759 Crook Veronica Elizabeth(nee McKenna) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Evans Funeral Chapel Nov. 24, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland . Signature of Funeral Service Licensee 22. Name and Address, of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2225 Vork Road Timonium, Maryland 21093 211 325 York Road Timonium, Maryland r complications that calsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Ever the disease shock, wheart failure. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) CARDIOGENIC SHOCK Medical Due to (or as a consequence of) Examiner Arrythmia Sacruar fielly list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury burial-transi signed by the attending physician and deequed be detached for use as the burial-tran that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical #スプルナー Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XNo 1 Yes 3 Probably 4 Unknown should this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 \square Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 🗌 Yes Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury Natural 5 Pending 2 🔲 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one MAIL 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mo D0063974 09

Registrar

State

ER DRIVE

TOWSON, MARYLAND

21204

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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IMRAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38657 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:02 Harry Linwood Custis Medical 2009 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9809 Forge Road Perry Hall Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖳 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 217-24-6864 Director lar 27 1930 Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Perry Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9809 Forge Road 21128 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

Yes 2 No Black, White, etc. 1 Never Married 2 Married 1948 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Black 3 Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Pasadena Super life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Meryl Custis Mildred Laws 19a. Informant's Name/Relationship (Type, Print) Daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine P. Churchill 7638 Fairbrook Road Windsor Mill, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Garrison Forest Vet 4 Donation 5 Other (Specify) Owings Mills, MD 22. Name and Address of Facility Chatman-Harris Funeral Home Reisterstown Rd Baltimore, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: MA 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 4 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 5 performed? Cabellone this certificate 2 🗌 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? To 1 🗌 Yes 2 4 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. lace of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29b. Signature and title of certifier

only one)

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32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

St-Ballimore M

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 20:22 PM December 2009 Vatalie 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bayview Hopkin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🛱 F 219-01-7675 87 2-4-1921 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ∏Yes 2 X No Baltimore Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21236 4216 Winterode Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Adjuster Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olympia Fortuna Natali 19a. Informant's Name/Relationship (Type. Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4216 Winterode Way Perry Hall, Md. 21236 Natalia N. Bahr -daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Oaklawn Cemetery 12-7-09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H 21. Signature of Juneral Service Licensee 263 S. Conkling St. Balto. Md. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Par 1 Enter the dise shock, or heart fail re. Approximate Interval Between Onset and Death Immediate Cause (Fix I disease or condition resulting in death) Sepsis hour Due to (or as a consequence of) Mesenteric Ischemia Sequentially list conditions Dusity (or as a consequence of)

Physician /Medical **Examiner**

burial-trar

attending physician for use as the burial

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certificate

24 hours after death. Puneral Director: A

within 2.

filled in by the

Medical

State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

Examiner

10a. State

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Funeral

Director

Show

Director

Funeral

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Completed

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Department of Health and Mental Hygiene. Important: jor items 23a or 28a-i shov important: if item 27 is marked other than "natural", or items 23a or 28a-i shov any injury or other traumatic event, the Medical Exaction in the modified at

Pages 1 and 2 should be filed within 72 hours after death

Maryland 21215-0036

Baltimore,

with the Maryland

/Medical

dany, leading to minedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No

1 Natural

29a, Certifier

Examiner Physician/Medical 2 Completed Be Certification: To 27. Manner of Death 2 Accident 3 Suicide 4 Homicide

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4 Pregnant at time of death 9 Unknown

Atherosclenosi

Due to (or as a consequence of)

3 Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes

23d. Date of delivery

24a. Was an autopsy perform 1 ☐Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

Avenue

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 M.D Eastern

Hospital

STYUNK 31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 Pending investigation

6 ☐ Could not be



Baltimore, Maryland 21215-0036 The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 9,11,12,15,16a-b,17,18,19a-b,20a-c,22, per Fh 8898 12/4709 TT

State of Maryland / Department of Health and Mental Hygiene 1- Registrar #20a-c, perFH, G898, 12/16/09, WS Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5, 200° **Physician** JOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Min Days 1 □ M 2 🔽 F 68 2, 1941 Maryland Director 220-40-8022 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2; ☐ No Funeral Director Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 USA 3000 N. Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ∐Yes 21X No Specify. Specify: black þ 3 Widowed 4 Divorced Completed unk 1117 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Animal Tech. **Hospital** unk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ပ William Clanton Mozelle Williams 19a Informant's Name/Relationship (Type Print)

Yvette Yarberough/ Daughter

Howard County Coneral Hoop 19b Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code)
400 Maple Lane, Dundalk, MD 21222
5755 Gedar Lane Columbia, MD 21044 20b. Place of Disposition (Name of Green Mountain) 20a. Method of Disposition 20c. Location - City or Town, State 12-11-09 1 Burial 2 Cremation 3 Removal from State rk 12/5/2009 S2. Name and Address of Facility Vaughn C. Baltimore, MD Greene F.S. 5 Baltimore St in state King Park 21. Signature of Funeral Service ROTIA Ld S Wade 21201 21229 Baltimore Nat'l Pike MD m Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and s the burial-trans resulting in death) Last Due to (or Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has brector, page 2 sl autopsy 2 100 1 ☐ Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 / No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient ဥ 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 1 Natural funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation ours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 15 Z000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2.1201. MOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2009 Registrar

			For State Registrar	State of Ma		partment of I ertificate of				38660
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Thomas G. Crit	zman				Novembe	er 14, 200	9 8:30 PM M
a.	Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Deat	4c. County of D	eath	
1			3405 Walbrook	Avenue		Balti	more			
	Funeral				(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h 9.1	Birthplace (State or Foreign
	Director		215-46-9090	1 ∑ M 2□F	62 Yrs	Wioritris Days	Tiodis Willi.	Mar 10,	7 1947 Ma	fylknd
	p.		Usual Residence of Decedent		10. 0	1				10d. Inside City Limits
	arylar show	_	10a. State 10b. County		10c. City, Town or					1 ⊠Yes 2 □ No
	8a-f	Sct	MD		Balti					
	or 2	ä	10e. Street and Number			10f. Zip Code	216		10g. Citizen of What USA	Country?
	urs after death with the Marylan ral", or items 23a or 28a-f show Expriner must be notified at	Funeral Director	3405 Walbrook A							
	er de	E	11. Marital Status	12. Was Decedent E Armed Forces?		 Was Decedent of I If Yes, specify Cub 	an, Mexican, Puer	to Rican, etc.)	Black, W	merican Indian, hite, etc.
36	saft ,or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 21X1N If Yes, Give Year or Dates:	10	1 □Yes 2X No	Specify:		Specify:	white
21215-0036	hour tural	Pa	15. Decedent's E		16a De	cedent's Usual Occu	nation	unk	16b. Kind of Busine	ss/Industry unk
5	n 72 ""na	Set	(Specify only highest gi	rade completed)	(G	ve kind of work done b. DO NOT use retire	during most of wo	rking		
712	withi	Completed	Elementary/Secondary (0-12) unk	College (1-4or 5 unk	+)					
b	filed I Hyg other ent,	Be C	17. Father's Name (First, Middle, Las	it)		 -	18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Medical Evaninar must be notified at	10 B	Thomas Critzma	an			Doris	Critzman	n	
ary	shou and N s mai		19a. Informant's Name/Relationship		19b. M	iling Address (Street	and Number or R	ural Route Numbe	er, City or Town, Stat	
Ž	alth alth 227 is		Christina Petti,	ie Balti	nore, MD	21216				
Ĵ.	of He		20a. Method of Disposition	_	ice)	Date	20c. Location - City	or Town, State		
Ē	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🖾 Other (Spec							
Baltimore,	permit. Departn Importa any Inju		21. Signature of Euneral Service Lice ROMA IO	ensee ale Dir	ector	State and Add	%nfyac Boar	d 655 W.	Baltimor	e Street
Ö	9 E 8 9		Sann	///XVV		Baltimore,				
			23a. Par 1. Enter the disease, or con shock, or heart failure. List only	mplications that caused	the death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Live	/		month	(Onset and Death
	/Medical		resulting in death)	- a	a consequence of):		innth	,		
	Examiner		Convention, list conditions	, Cirv	hosis		Year	\$		
	p ±	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):		1			
	nd rrans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
ó,	icate be executed physician and the burial-transit	Ě	resulting in death) Last	Due to (or as	a consequence of):					
8760,	ate b	dical	•	d						
9	ertific ling p	Mec	IF FEMALE:							
Вох	eath certific attending p for use as 1	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnan	су		23d. Date of Month	delivery Day Year
0	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify) ₋				
σ.	that the		Part II. Other significant conditions	contributing to death by	ut not resulting in th	underlying cause gi	ven in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
Records,	0 50	by	and the state of t	out in the second secon		g.		1 🗆		Probably 4 Unknown
Ö	w require been signated should b	Completed								
3ec	elaw hasl	Jdu						24a. Was autop		e eutopsy findings available to completion of cause of h?
=	ician: The certificate hisector, page	CO						1 □ Yes	2 No 1	Yes 2□No
Vital	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?	Hospital:		Ot	hor:	ath (Check only o		thiac
o	Phys this al dir	-T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpa	tient 3 L DOA	4 □ Nursing I	· · · · · · · · · · · · · · · · · · ·	dence 6 Other (how injury occurred	Specify)
n	ing After une	ion	1 ☐ Natural 5 ☐ Pending	(Month, Da		y Wo	rk? □Yes 2 □No	200, Describe	now injury occurred	V
Si	death death stor: / the	ical	3 ☐ Suicide 6 ☐ Could not	be 290 Place of Inju	ırv - At ho <i>m</i> e, farm.	street, factory, office	1163 2 1140	28f Location /	Street and Number o	r Rural Route Number,
Division	or A after Direc	Certification: To	4 ☐ Homicide determine	building, etc	c. (Specify)	and on the same		City or To	wn, State)	
_	spital ours neral filled			Physician: To the best						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	(Check only 2 ☐ Medicel Example)	aminer: On the basis o and manner sta	f examination and/o ated.	r investigation, in my	opinion, death occ	urred at the time,	date end place, and	due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	110	113	29c. Licen	se number		29d. Date signed (N	fonth, Day, Year)
			1	110	, / 1)	, D	66556		11/20	/u/
			30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Ty	pe, Print)) 1	A. (F	> 11/	MD 21201
_				arhavi	HCH		WAK YN	re p	>u I Time	10 y = 120
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	No.				
	109131		DLU U - WO		-					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20a-c&22, perFH, G898, 12/17/09 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25 Month Journ **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 42 212-06-7450 Jan 14, 1967 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code unk USA 5817 Willowstown Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: black þ 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 1egal secretary Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other transment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearlie Wooten Luther Morrisey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Larry Morrisey/brother 6724 Ransome Drive Baltimore, MD 21207 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Zion Cemetery 12/12/09 Baltimore, Maryland 5 X Other (Specify) 4 Donation in state 22. Name and Address of Facilit Howell Funeral Home State Anatomy Board 655 W. Baltimore Street 4600 Liberty Heights Ave. Balto. MD 21207 21. Signature of Funeral Service Licenses Ronald S Wade Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between shock, Onset and Death Immediate O use (Final **Physician** ACUTE MYOCURDIAL INFARCTION disease or condition resulting in death) /Medical Examiner Thrombotic thrombocytopenic Purpura if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performe 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After it 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (check only anel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-DDO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

HAVERS

4 2009

FIONA

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38662 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1,37 AM P November 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HARFOR 8. Date of Birth (Month, Day, Year) APRIL 29,1916 (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □ F Months Days Hours Min. 226-12-2730 93 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No MD HARFORD BELAIR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1909 EMMORTON RD 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ϊ No WHITE Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COSMOTOLOGIST COSMETICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN RODEFER MYRTLE COMPTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOYCE MERSHON-DAUGHTER 4114 MANOR VIEW CT JARRETTSVILLE, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ATLANTIC CREMATORY 12/8/09 GLEN BURNIE, MD 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRUNIC OBSTRUCTIVE PULMOMARY Due to (or as a consequence of): Sequentially list conditions,

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mostreal Examiner must be notified at annex.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Be Completed by

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attending physician and for use as the burial-transit certificate has been signed by the rector, page 2 should be detached 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,								
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic			23d. Date of delivery Month Day Year					
ed by Ph	Part II. Other significant conditions of		, ,			co use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
Complet	GERD.				24a. Was an autopsy performed 1 □Yes 2						
Be (25. Was case referred to medical	26. Place of Death (Check only one)									
	examiner? 1 ☐ Yes 2 Z No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 ☐ D	OA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Specify)					
ation:	27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in						
Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ry, office	28f. Location (Street City or Town, St	Street and Number or Rural Route Number, vn, State)					
Medical (nysiclan: To the best of my kniner: On the basis of examinand manner stated.				e(s) and manner as stated. and place, and due to the cause(s)					
Me	29b. Signature and little of certifier		29	9c. License number	29d.	Date signed (Month, Day, Year)					

State

Registrar

SURESH

29b. Signature and little of certifier

DHANJANI

29c. License number

29d. Date signed (Month, Day, Year)

within 24 ho

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** miels VICICIC 26 lovember 200 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Examiner Endallstour Homital Center thwest Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex . Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. 1 ☐ M 2 ▼ F Months Davs Hours Director 5-27-1954 New Jerrey Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moderl Examine 1, sist by notified a once. 1 ☐Yes 2 No Director Baltinore Reisterstam 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12011 Tarragon Road 21136 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married Specify: African-American Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hyatt/Ameri Suites Hospitality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bugene Daniels Dorothy Thomas ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shana Daniels-Franklin/Dauchter 10904 Hintcliff Drive#10, Ovings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 12-5-09 Bauwiew Cemetery Jersey City New Jersey 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randalistown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final alleli **Physician** 4/10/01C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Table Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a conseque ce of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) leral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□N0 24a. Was an autopsy 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 □No investigation 2 ☐ Accident To the Hospital or Attenowithin 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO052760 November 26, 2009

State Registrar Erica Tobin

31. Date filed (Month, Day, Year,

4 2009

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Court Read Randall trun, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

vou

32. Registrar's Signature

09-09267 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sherri Delauder State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month November 29, 2009 0915 hrs Medical Examiner Sherri L. Delauder 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Baltimore County** 906 Catawba Court Halethorpe 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director 1 M 2 XF 40 Feb. 3,1969 Country) MD. 213-06-8399 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County 1 Yes 2 X No Lansdowne Baltimore with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 906 Catawba Court 21227 United States Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes White Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 3 Widowed 4 XDivorced If Yes, Give Yea Specify: Yes 2 y No specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than 21215-0036 12 Disabled Disabled 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) is marked Naomi Herbert Ε. Balzanna Ott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 5220 Wasena Avenue Brooklyn, Maryland 21225 If item 27 Balzanna/ Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 crematory or other place) Removal from State Dec.4,2009 |Hampstead,Maryland Grave Run Cemeterv Donation 5 Other Specify: 21 Sign ture of Funeral Service Licenses AMBROSEATUNÉRALY HOME OF LANSDOWNE 2719 Hammonds Ferry Road Lansdowne, MD. 21227 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED ed by the attending physician detached for use as the burial AMENDED 23a,27,PII,per ME g899 1/15/10 TT The law requires that the death certificate be Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Status-post mitral valve replacement; obesity Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has death? performed? 1 ✔ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 2, 2009 O.C.M.F.

Zabiullah Ali, M.D. Assi
31. Date filed (Month, Day, Year)

DEC 0 4 2005

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TILEM#20a, c&22perFH, G898, T2/15/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 23:30 PM Patricia Doles 200 MOU Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Oct 10, 1951 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 👿 F 58 **Director** 214-62-3776 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ¥ Yes 2 ☐ No MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2327 N. Charles Street 21215 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Force 1 Yes 2 No 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: black 3 Widowed 4 X Divorced Completed Year or Dates unk 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) cosmotologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Alfred Doles Miriam Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Claflin Court Bsltimore, MD Erica White/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 W Other (Specify) in stat Baltimore, Maryland Charisse, N. Woods, F/S, Street at of Final Servi 2700 Edmondson Ave Baltimore, MD 21223 irector art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Severe L Wieek disease or condition Medical Due to (or as a consequence f): wiway hact which con resulting in death) **Examiner** ell mouths Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Oronay Q O V Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month signed by the a Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ| 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 XYes 2 □ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X** No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: Of the basis of examination and of investigation, it may obtain a date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) AT 2438946-B4 MN11/19/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, Balkimore, HD 21218 PASSER HOKAYEM

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician November 2 2009 Wanda R. Duckworth /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** narlestour atonsville TIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 □ M 2 1 F 86 Director 169-16-0157 Feb 1. Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show 1 □Yes 2 No Director Baltimore Catonsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 **USA** 715 Maiden Choice Lane Apt. CR507 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Accounting th and Mental Hygie 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Roskowski Stephania Sztukowska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Joseph Duckworth, Son 2110 Buttonwood Road Berwyn, PA 19312 Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
The First Baptist Church 12/07/09
The First Baptist Church 12/07/09
The First Baptist Church 12/07/09
The First Baptist Church 12/07/09
The First Baptist Church 12/07/09
The May Court House New Jersey
The Mac Nabb Funeral Home P.A. 301 Frederick Road Catonsville, Maryland 21228 20a. Method of Disposition 1♥ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor romo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or explications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. rdiovascular Diseas Immediate Cause (Final erosc e rotic Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Year 5 Other (specify) □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe rmed? 2 No 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Monner eath 1 Unatural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 🗆 No 2 Accident **Director:** 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

20

Maide

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

4

avid Eisenhart			nt of Health and Mental H e of Death	ygierie Reg. No	2009 3868
Physician/	1	David Elliot Eisenhart		2. Date of Death Month Day November 24,	3. Time of Death 2009 0005 hrs
edical Examiner		David Elliot Eisenhart a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 4	c. County of Death
)	Ļ	Baltimore Washington Medical Center	Glen Burnie av) If Under 1 Year If Under 24Hr		Anne Arundel M/DD/YYYY) 9. Birthplace (State or
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthd 1 X M 2 F 46	yrs. If Under 1 Year I If Under 24Hr. Months Days Hours Mir	_	Foreign
any	_	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
and f show once.		MD Anne Arundel Severn		1400 0	1 Yes 2 X No
72 hours after death with the Maryland n "natural", or items 23a or 28a-f show any al Examiner must be notified at once. leted by Funeral Director		2600 Annapolis Road	10f. Zip Code 21144	Uni	ited States
or tems 23	1	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. White
5-0036 led within 72 hours after d stygiene. other than "natural", or the Medical Examiner in Completed by Ft	<u>`</u>	3 Widowed 4 Divorced If Yes, Give Yeer	Yes 2 No specify:	work done 16b	Specify: Kind of Business/Industry
5-0036 ed within 72 hourn tygiene, other than "natu the Medical Exam Completed	2	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NDT use re	tired)	
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		77. Father's Name (First, Middle, Last) John Dean Eisenhart		cy Jane Fis	
2121; ould be fill d Mental H s marked lite event, To Be		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or 749 Beach Road, Med	Rural Route Number,	City or Town, State, Zip Code)
O -5 -6 -7 -8		riand, barre	Disposition (Name of cemetery,		c. Location - City or Town, State
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If tiem 27 injury or other traum.		1 Burial 2 X Cremation 3 Removal from State cremator	u or other place)	/04/2009 G	len Burnie, MD
altim nit. Pa artmen sortant ry or o		4 Donation 5 Other Specify: 21. Signature of Fyreral Service Licensee T. Harman	22. Name and Address of Facility	Waite & So:	n Funeral Homes
Be Pe Be in the lead of the le		TSON	765 N. Court Stre		
Physician Medical	1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		or respiratory arrest, s	Between Onset and Death
saminer		Immediate Cause (Final disease or condition resulting in death) a. Myocardial fibros Due to (or as a consequence of):	sis and scarring		
ner	2	Sequentially list conditions, if any, leading to immediate cause. Enter Unidenying Course			
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50, te be executed sysician and burial - transit			ME g898 1 <u>2/30/09</u>	TT	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic preg		23d. Date of delivery Month Day Year
Box death of the atter) Jac	1 Yes 2 No 9 Unknown g Unknown	Dther (Specify)		
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duires I	Ted c			24a. Was an	24b. Were autopsy findings availab
COFC e law re e has be	Completed			_ autopsy performer 1 ✓ Yes 2	
I Re		25. Was case referred to medical	26.Place of Death (Che		
Vita hysicia this ce Il direct	o Re	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou			sidence 6 Other:
ding Ph		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. T	ime of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the restler death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach that the control of the page 2 should be detach the page 2 should be detach that the page 2 should be detach that the page 2 should be detach by the control of the page 2 should be detach by the page 2 should be detach by the page 2 should be detach by the page 2 should be detach by the page 2 should be detach by the page 2 should be detach by the page 2 should be detach by the page 2 should be detach by the page 2 should be detached by the page 2 should be detached by the page 3 should be detached by the b	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, Cit
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the confice of the funeral director, page 2 should be detached for use as the		4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: Dn the basis of examination and/or in	th occurred at the time, date and place, a	and due to the cause(s) and manner as stated.
To the within To the complete	Medical	one) 2 Medical Examiner: Dn the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
		W//2 MD	O.C.M.E.	1	November 24, 2009
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201	
Stat Registra	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	back		
DHMH 17 Rev 1/200			IGINAL		

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Amend #9 per ANA BD G898 12/11/09 In

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	i waryiano		artment of F tificate of £			giene Reg. No. 2 () ()	9 38668				
	Dhyminia	/	Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death				
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign					
	Director		309-18-9431 ^{1 図 M 2 □ F}	Prince Pr										
	show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Loc	ation			-	10d, Inside City Limits				
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Maryland 21215-0036	e filed within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fi	1 Never Married 2 K Married 1 Never Married 2 K Married 3 Widowed 4 Divorced If Yes, Giv Year or Da	rces? 2 No e	- 1	Vas Decedent of Hi Yes, specify Cuba		Rican, etc.)	Black, W	American Indian, Vhite, etc. White				
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	1 and 2 should be if Health and Men item 27 is marke other traumatic		Erna Edmonds/spouse			g Address (Street a			; City or Town, State, sda, MD	, Zip Code) 20817 ————————————————————————————————————				
Baltimore,	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 🔀 Donation 5 🗗 Other (Specify)		ce of Dispos netery, crem	sition (Name of natory or other plac	e)	Date	20c. Location - City	y or Town, State				
Bal	permit. Page Department Important: I any injury or		21. Signatur Fineral Trice Signatur Fineral Fin											
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ecol	law has	Completed by						24a. Was a autops perfor	sy prior med? deat					
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n of	nding P tth. : After t e funera	cate:	27. Manner of Death 1 X Natural 5 Pending (Mont) 2 Accident Investigation	of injury h, Day, Year)	Bb. Time of injury	28c. Injury work' M 1 🗌	rat ' ? Yes 2 □ No	28d. Describe ho	ow injury occurred					
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	I Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At home ng, etc. (Specify)	e, farm, stre			28f. Location (St City or Town		Rural Route Number,				
	e Hospit 1 24 hour e Funera leted fillk	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the b 2 Medical Examiner: On the bas 3 Certifying Nurse Practioner:	is of examination ar	nd/or investi	gation, in my opinio	n, death occurred a	at the time, date an	nd place, and due to t	the cause(s) and manner stated.				
	To th withir To th comp	2	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo					
			· San			D30	1/32		11/18/0	9				
			30. Name and address of person who completed caus M - RITA GH OSH M-D	e of death (Item 23	Ba) (Type, Pr	rint) SICIANS	LANGT	=161 ROC	KULLE,	19 MD. 2185V				
	Stat Registra		31. Date filed (Month, Day, Year)	egistrar's Signature	ba	NED)								

Division of Vital Records, P.O. Box 68760, the Hospital or Attending hours after within 24 hours a

State Registrar

31. Date filed (Month, Day,

aly, somp

29b. Signature and title of certifier

(Check only



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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villa

era, Cenp 25 200

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arvey Lee Fishe	1	Sta	te of Maryla	•	artment of rtificate of		l Mental	Hygiene	Reg. No.	200	9	3867
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle, Harvey Lee Fish	,					2. Date of D Month Decemb		Year		of Death 3 hrs
		4a. Facility Name (if not institution, Southbound Interstate 9	give street and nun		4	b. City, Town, or L Rosedale	ocation of De		40	County of Dea		
Funeral Director			. Sex	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min	,		ountry)	State or Foreign
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Rer d	— L		12. Was Dece Armed For 1 X Yes ced If Yes, Give Year	2 No	If Y∈	21078 Decedent of Hispers, specify Cuban,	Mexican, Pue	(Specify Yes or erto Rican, etc.)		SA 14. Race - Ame White, etc. Specify: Wh		an, Black,
5-0036 led within 72 hours al tygiene. other than "natural the Medical Examin	mpleted	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-		during mo	's Usual Occupation of working life. Driver				Kind of Business		ies
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica.	8	17. Father's Name (First, Middle, L Chandler Taylor 19a. Informant's Name/Relationshi	Fisher		19h Mailing	Address (Street	Doroth		abeth	Timmon		40)
nore, MD 2121 ages I and 2 should be file of Health and Mental B t: If item 27 is marked other traumatic event,	1	Judy Fisher / W	ife		1015 C	tion (Name of cen	ke Driv		re de		MD 2	1078
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other Spe	cify:	iii State		emorial (l Air, I		and
면 됩니다. Physician	+	THE THE TAX TO A TAX A	now that ca	used the death		ame and Address COMAS Fi 317 Cokes e mode of dying, s	inerál sbury I such as cardia	Home, I Rd., Abi ac or respiratory	arrest, she	n, MD 2.	Appro	ximate Interval
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cox 68760, cath certificate be execut attending physician and for use as the burial - trans	≅t	UNPENDED IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, o	utcome of preg		al death 3	.Ectopic pre	egnancy	23	d. Date of delive	ery Day	Year
Box 68760, he death certificate be the attending physic hed for use as the bur	lys.	past 12 months? 1 Yes 2 No 9 Unkn	own 9 Unknow		eath 5 Oth	er (Specify)						
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To the Hospital within 24 hours To the Funeral completely filler	edical	one) 2 Medical Exam	sician: To the best iner: On the basis of and manner sta	f examination a		on, in my opinion,	death occurre		ate and pla	ace, and due to	the cause(
	2	29b. Signature and title of certifier	_			29c. License				Date signed (M		Year)
1041		30. Name and address of person w Ana Rubio MD. Assis	ho completed cause stant Medical E		,	treet, Baltimo	re, MD 21	201				
Sta Registr	_	31. Date filed (Month, Day, Year)	2009 32. Res	gistrar's Signati	ure A. A.	Mad	-					

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 3, 2009 12:30A M Elizabeth Forrest Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk Future Care Eastpoint If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F 0370671924 Mary land 217 16 5813 85 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Essex 10f. Zip Code 21221 10e. Street and Number 10g. Citizen of What Country? Funeral 1910 Sue Avenue 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married þ 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 X Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Executive House Keeper Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) snould be file th and Mental H ည Alverta Barrows Frank Forrest. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 North Trail Way Parkville Maryland 21234 . Page 1 and 2 sh iment of Health a tant: If item 27 h Elaine McCollogan (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem 12/5/2009 Baltimore, Maryland ☐ Other (Specify) 21. Sign 22 Name and Address of Facility atu e of Funeral S, rvice Lice Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. P. rt 1. Enter the disease, or co sl. ck, or heart failure. List on mplications that aused the de-Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immedia e Cause (Final disease o condition resulting in death) ACCIDENT Pnysician/ EREBROVASCULAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the b IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? forι Month 5 Other (specify) 1 Yes 2 9 Unknown the detached 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending X Natural 5 \square Pending 1 Yes 2 No Accident Investigation 24 hours after deatl Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🖎 🛠 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the nd title of certifie Signature 29c. License number 29d. Date signed (Month, Day, Year) 00060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILADELPHA PS HANKA, T KHETERPA 9106 31. Date filed (Month, Day, Year) 37 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a per doc, 5,10e,19b per inf g913 3-14-11 vt State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	•	Certificate of			Reg. No. 2005	38672
	Physicia	an	1. Decedent's Name (First, Middle, L		:			2. Date of Dea	ath 8/2009 Year	3. Time of Death 4:30 a M
	/Medic	al	4a. Facility Name (If not institution, g	Gasperett:	<u>L</u>	4b. City, Town,	or Location of Death		4c. County of Deal	
1	E.Xaiiiii	e.	1316 Benwick	Lane #1118	8		Spring		Montgom	ery
ı	Funeral Director		$046 \frac{-28}{29} - 9018$	Sex 7. Age 1 X M 2 □ F	e (In yrs. last birt	thday) If Under 1 Yea Months Day		8. Date of Birt (Month, Da 03/09	y Year) 9. Bird 0/1926 New	hplace (State or Foreign unitry) York, NY
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	ne Man 8a-f s	Director	MD Montgo	mery	Silver	Spring			10g. Citizen of What Co	Y Yes 2 No
	th with the 23a or 2	al Dire	1316 Henwick Benwick	Lane #111	8	10f. Zip Code 20910-			USA	ountry ?
036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Evartinal must be multihad at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Co		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
		Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	grade completed)		Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	cupation se during most of wor red)	rking	16b. Kind of Business	Industry
7	giene giene	Com		College (1-4or 5		Teacher				lic Schools
⊆	d d d	Be	17. Father's Name (First, Middle, La						Maiden Surname) narevale-H	Ronino
<u> </u>	should and Mer s marke umatic	2	Hannibal Gasp 19a. Informant's Name/Relationship		19h	Mailing Address (Stre			er, City or Town, State,	
	s 1 and 2 shou f Health and ∿ item 27 is ma other trauma	Ш	Stephen J. Gas	peretti/S	on 69					, MD 20743
Se,	es 1 al of Hea fitem rothe	l i	20a. Method of Disposition		20b. Place of cemeter	Disposition (Name of ry, crematory or other p		Date	20c. Location - City or	
Ĕ	Pages ment of ant: If it ury or c		1 \square Burial 2 \square Cremation 3 4 \square Donation 5 \square Other (Spe					11/30/0	9Washingt	con, D. C. neral nome
Baltimore,	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service License Terry A. Au	1 /	I date	m+<				n, DC 20011
9	Physician	8 1	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that baused aly one cause on each lin	ne.	not enter the mode of c	dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)		a consequence	4	0 1			
	Lammer	ē	Sequentially list conditions, if any, leading to immediate	b. Conges Due to (or as	a consequence	heart	failu	re		years
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68760,	rificate be executed ng physician and as the burial-transit	cal Ex	resulting in death) Last	Due to (or as	a consequence	of):				
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O. Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
ds, P.	w requires that the second second by second		Part II. Other significant condition	s contributing to death b	out not resulting in	n the underlying cause	given in Part 1.	23e. Did t	obacco use contribute t	o the cause of death?
Records,	aw requ as been 2 should	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
al Re	tending Physiclan: The law leath. Ior: After this certificate has the funeral director, page 2 the							perfo 1 ☐ Yes	ormed? death? 2 ☑No 1 ☐Ye	s 2 No
Vital	siclar s certil	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 FR/O	utpatient 3 DOA		ath (Check only o	one) dence 6 □Other (Sp	ecify)
ا ا	og Phy ter this neral d	n: To	27, Manner of Death	28a. Date of Inju	ury 28b.	Time of 28c. In	njury at		how injury occurred	
Sior	Attendin death. ctor: Af y the fur	catio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion		M 1	□Yes 2□No			
Division of	2 0 0 >	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	20e. Place of III	jury - At home, fa tc. <i>(Specify)</i>	rm, street, factory, offic	ce	28f. Location (City or To	Street and Number or F wn, State)	Rural Houte Number,
	To the Hospital or Attending Physiclan: within 124 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; p	Medical Co	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best kaminer: On the basis of and manner st	of examination ar	e, death occurred at the	e time, date and plac ny opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner and date and place, and du	as stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	0 0			ense number		29d. Date signed (Mor	th, Day, Year)
			marttu	8 Dan	vedn	P	004117	3	12-1-0	9
	$\widehat{I_D}$		30. Name and address of person w	no completed cause of C	death (Item 23a)	(Type, Print)				
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature					
	Registr	ar	DEC 0 4 2009	Chrone	A. 130	RAFTERNA				

State of Maryland / Department of Health and Mental Hygiene 38673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joscelyn A. Goodall p. M 2009 December 4:16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Glenshire Court Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1X M 2□ F Months Director 215-84-3839 Jamaica Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, in Mental and Mental Department. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Baltimore Ovines Mills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4 Gienshire Court 21117 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: Janacian 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright United Irons 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Goodall Egnita Codner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Glenshire Court, Owings Mills, MD 21117 Salonie Goodall-Taylor / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-12-09 Woodlawn cametery Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility While funeral Home PA of Baltimore Co. Muda 9200 Liberty Road, Randallstown, MD 21133 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Medical Certification: To Be Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;

completely filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D D5059107 12-2-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS REISTERSTOWN MD 21136 DRIVE UMA CENTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Florence Rose Gottleib 03:59 2 /Medical Vovember 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Baltimore HUSDITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country, MD **Funeral** Months Days Hours 1 □ M 2 🛛 F Director 212-34-3140 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be refined once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Halethorpe Director 1 ☐Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 2832 Tennessee Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ZNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Inspector Lowery Carr 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Marie Catherine George Wakefield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna LaFoille-daughter 15 N. County Road 441 Manistique, MI 49854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 12-3-2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne suchelo 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MOXIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) o signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ Stage renal 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 1 □ Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Division of Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending n 24 hours after death. • Funeral Director: A oletely filled in by the fu investigation 1 🗆 Yes 2 🗆 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 **Fo the i** 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming-HSi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2,2009 2:02 p December Minnie Elizabeth Geppi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6515 Posemont Avenue Baltimore Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min 215-22-5714 82 11-20-1927 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I're Medical Examinar must be notified at 1 XYes 2 No Director N/A MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6515 Rosemont Avenue USA 21206 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ₩No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Edward Rumney Nannette C. Howe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Robert W. Walizer (Nephew) 6515 Rosemont Avenue, Baltimore, Maryland 21206 Baltimore, Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Meadowridge Memorial 12-07-09 Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications ther caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be execute and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ ₩6 detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but of ot resulting in the user ying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 🗆 Yes 2 🔲 No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to predical examiner? funeral director, 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check onl) one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature as 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5tt 302 AVI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ribson 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Dec 8 Country)
Maryland Days 1 X M 2 1 1943 220-40-8297 Director 65 Usual Residence of Decedent 28a-f shov 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1√2 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 218 S. Augusta Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: black Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 truck driver transportation Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hw Important: If item 27 is marrany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilbert Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 s. franklintown Road Baltimore, MD 21223 Wilbert Gibson/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state Funeral S rvio Licensee Signatur State Anatomy Board 655 W. Baltimore Street Raltimore. MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Oause (Final Physician, disease or co Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dae to (or as a nonsequence of, as the bunal-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\Bigcap \) Nursing Home 5 \(\Bigcap \) Residence 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide
4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -20-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

4 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #14 Pegrate of Maryland Department of Health and Mental Hygiene 2 0 9

1- State Amedn 4c, per MD g900 2/25/10 TT Gertificate of Death

Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Howard 11:19P.M brember 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Dorchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days 33 Nov.6,1976 212-94-4841 Marvland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No MD Cambridge 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 916 Peachblossom Ave. 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. 1 Yes 2 If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Private 12 Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Ruth Hurley Unknown 19h Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 5303 Suburban Drive 19a. Informant's Name/Relationship (Type. Print) Cambridge, MD 21613 Sharon L. Shorter/Aunt 20b. Place of Disposition (Name of Howard Temperature of University Medical School 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/22/09 | Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home M00996 3821 14th Street, N.W., Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Immediate Cause (Final Monar diseas or condition resulting in death) AORTIC REGURGI MATION Gis quanticity fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? 1 ☐ Yes 2 XNo Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Box 68760, Division of Vital Records, P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed physician an Director: A n 24 hou.. the Funeral Dire

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trauonce.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Directo

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

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29b. Signature and title of certifier

OEC 0 4 2009

29a. Certifier

To the within 2

State Registrar

KARTHK SURES H 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

2009

November 21

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ²⁶, 2009 **Physician** C. Hayes November 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hammonds Lane Center Linthicum Heights Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-21-1918 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** Days Hours Min. 91 Director 211-01-9386 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County If Item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Eventual principled at 1 □Yes 2 No Anne Arundel Linthicum Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 USA 411 Linda Avenue Pages 1 and 2 should be filed within 72 hours after death wont of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: white þ Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Defense Industry Aerospace Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Hayes Florence Combs 19a. Informant's Name/Relationship (Type. Print)
Thomas W. Hayes/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5576 Spinnaker Drive Salisbury MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial | Dec. 4,2009 | Elkridge MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Ambrose Funeral Home Inc. curk 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) HASCU The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ermined 4 Momicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWNAPOLIS NOTED 21227 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hamilton Annette December 21:16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Center Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Min. June^{th, 2}7, 71960 Months Hours MAry Land **Director** 213-84-5488 49 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2776 Moorgate Road 72 hours after death with 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Dispatcher 12 years Transportation Be 17. Father's Name (First, Middle, Last) Should be file hand Mental Hand Mentel Hand Mentel Hand Mentel Hand Mentel Hand Mentel 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Hamilton Sr. Anne Kvech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Anne Hamilton Mother 1928 Ormand Road, Dundalk, Maryland Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December cemetery, crematory or other play Bayview Crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7, 2009 Baltimore, Maryland 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.

7110 Collers Point Road, Dundalk, MD. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure, List only one cause on each line. complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami and burial-trar Due to (or as a consequence of): resulting in death) Last the attending physiclan hed for use as the burian Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c, If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Inknown P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed To the Funeral Director; After this certificate completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 2 NO ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after building, etc. (Specify) Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

thous nay, Year) 31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who

only one)

ttarrel1 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

DEC V & LUUD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Dundalk. AVE.

29d. Date signed (Month. Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 HAZAR.D **Physician** BID AM 02 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🖫 F June 17. 1924 Illinois **Director** 85 <u>132-16-7508</u> Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment for rectified at 1 Yes 2 XNo Director Rockville MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20850 8 Baltimore Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, Ite Medical Examinating or other traumatic event, 1 ∐Yes 2 ∑XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🙀 No Specify: White ģ 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk County Courthouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary (unknown) Sam Soghigian ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1419 East Brooklake Drive, Houston, Texas 77077 (son) Richard H. Hazard 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Rockville, Maryland Parklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATIC NEOPLASM 7 MO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): NEOPLASM Examiner DLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 D No Day 5 ☐ Other (specify) nis certificate has been signed by the a director, page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 1 □Yes 2 □No 26. Place of Death (Check only one) Certification: To Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Mannef of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-2-09 DØØ6[382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14816 Physicians Lane #152 Rockville, MD 20850 Shama R. Mittal, M.D. 31. Date filed (Month, Day, Year) **DEC 0 4 2009** 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7:18 P NOVEMBER 29 2009 MAVIS JEAN HUFFMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 21 F Director 91 16, 1918 West Virginia 233-34-6828 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 □Yes 2 □No Director Maryland | Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 2300 Shannon Road 21040 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Luther Chambers Whitt Minnie Ethel Mitchum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2300 Shannon Road, Edgewood, MD 21040 Uria A. Huffman / Husband Department of Health Important: If item 27 any Injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 12-3-09 Owings Mills, MD 4 Donation 5 Other (Specify) McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician tool. disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence f) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ☐Yes 2☐No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗆 Yes neral birector: After this certificate has been silled in by the funeral director, page 2 should. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform (06D 2 **1**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural

P.0. HUFFMAN, MAVIS Division of Vital Records, Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination regains by notified at

n and Mental Hygiene.

27

sician and burial-transit

attending physician for use as the buria

signed by the a

Pages

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral C Medical completely Registrar

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifie

5 Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chesapeale Drive Bel Air, MD 21014 upper

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

and manner stated.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov Day **Physician** 2009 Toward Lee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore SymingTon atonsville wenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Se: . Age (In yrs. last birthday) **Funeral** 1√ M 2□ F Hours Country)
Maryland 216-42-0261 28, Director 67 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 125 S. Symington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No If Yes, Give Year or Dates: 160-6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: white 3 Widowed 4 Divorced 60-63 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrician Health and Mental Hygi∢ em 27 Is marked other i ither trau⊓atIc event, Ir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Frederick Hadel Sr ပ Mary Elizabeth Geldmacher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Lue Hadel/spouse 125 S. Symington Avenue Catonsville, MD 21228 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign ure Luneral Servi Licensee State Anatomy Board 655 W. Baltimore Street mector Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Immediat Cause (Final **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consecuence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No signed by the a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cate has been si page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 12 Natural 2 ☐ Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2 018587 on who completed cause of death (Item 23a) (Type, Print) Ave BaHIMOVE MD 2/279 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:30 AM M 17, 2009 November <u>Marcia T. Heaton</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 10567 Jason Lane 8. Date of Birth Jan 10, 1939 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F California 70 567-46-4325 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.4. any injury or other traumatic event, the Mental and India. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 USA 10567 Jason Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify Specify: White ₫ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall Kellogg Taylor 2 Zona Owen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Heaton/spouse 10567 Jason Lane Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Sign Iture # Funeral Service ROTUTO 22. Name and Address of Facility. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C e (Final disease or con in n resulting in death) **Physician** METERSTATIL Lung /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to initing a discause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1∐Yes 2∭ No ed by the a 9 Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 2 XNo 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After that in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide n 24 hours aft I**e Funeral Di** bletely filled ir 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 10 vember 23, 2009 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Koutrela Columbia Marylans 21044 Nicholas 2. Registrar's Si State Registrar

			1 - For State Registrar	State of Ma	ryland / Depa Cer	artment of H rtificate of L			iene	009	38684
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day	Year	3. Time of Death
	/Medic		Naomi D. Hardma					Novembe	r 19,	2009	7:15 PM M
	Examin	er	4a. Facility Name (If not institution, give			_	Location of Death			ounty of Death	
-	Ermanal	-	Manor Care Ruxt 5-Social Security Number 6. Sec		(In yrs. last birthday)	TOWSON If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Baltimo	place (State or Foreign
	Funeral Director			M 2₹F	92 Yrs.	Months Days	Hours Min.	Apr 18,	Year)	Con	nsylvania
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo		·				
	l show	ក	MD Baltimor	e	Balti						10d. Inside City Limits 1 ☐ Yes 2√☐ No
	28a-f	rect	10e. Street and Number		Daren	10f. Zip Code			Og. Citizer	n of What Cou	
	h with	io is	8125 Glen Gary R	oad			21234			USA	,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental tyglene. Department of Health and Mental tyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinational London 2006.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	lo	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🂢 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: wh	etc.
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<u>0</u>	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		1081	Beered III	18. Mother's Nam	e (First, Middle, I			are
lan	uld be Jenta rked tic ev	To B	Edward John Chell				Catherin	e Elizab	eth 1	Doll	
Maryland 21215-0036	nd 2 sho alth and 1 27 is me	Ī	19a. Informant's Name/Relationship (Ty Barbara hardman/c			ng Address (Street a 5 Glen Ga					
altimore,	Pages 1 annent of Heanant: if item		20a. Method of Disposition 1 Burial 2 Cremation 3 F 1 Donation 5 Other Specify)	10//	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Loca	tion - City or T	own, State
Balt	permit. Departi importi any inj		21. Signature of Funeral Stylice Licens.	XXXXX		Name and Address ate Anato			Balt:	imore S	Street
<u> </u>	Pnysician	•	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each lin	the death. Do not ent				est,		Approximate Interval Between Onset and Death
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58760,	ate b	dical		d						-	
Box (death certi e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	very Day Year
P.0	The law requires that the steep seem signed by the sage 2 should be detache	/ Ph	Part II. Other significant conditions cor	ntributing to death bu	at not resulting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use	contribute to	the cause of death?
ds	quires n sign	d by						1 □ Ye	es 2 🗆 l	No 3□Pro	bably 4 Unknown
Records,	s been s been s should	Completed						24a. Was a	n 2	24b. Were aut	opsy findings available
	The law cate has page 2:	mo:						autops perform	med2 No	death?	ompletion of cause of
<u>ta</u>	ı lcian: Th certificate rector, paç	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
>	Physician: this certifica ral director, p	2	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatie			4 Nursing Ho	ome 5 Reside	ence 6	Other (Spec	ify)
2	Jing After fune	ation:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of Year) Injury	Worl	yat (? Yes 2 □ No	28d. Describe ho	ow inju ry d	occurred	
DIX	Dirte o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc	iry - At home, farm, str (Specify)	eet, factory, office		28f. Location (St City or Town		Number or Rui	ral Route Number,
	To the Hospital within 24 hours to the Funeral completely filled	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	ne: On the best of and manner sta	of my knowledge, death examination and/or in- ted.	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause(s)
	To the vithing to the total company of the total co	Ž	29b. Signature and title of certifier	no		29c. License	number	2		signed (Month	•
)			1 ///			220	2749		11-	23-00	1
			30. Name and ess of person who co	ompleted cause of de	eath (Item 23a) (Type,	Print)	2002	5 15	ماد		
	Sta	to	31. Date filed (Month, Day, Year) vnn	32. Registra	ur's Signature	0.00	2110 J	2 91-	0		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:43 a^M November 29 2009 JIGGETTS **DELORES** VIRGINIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE 137 N. CULVER STREET If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F JUL 11 1932 MARYLAND Director 218-28-7492 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 28a-f shov 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Exarcine roust be notified at tXXYes 2 ☐ No Director N/A BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 137 N. CULVER STREET 21229 Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ ▼ o If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2XXXIo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE CITY 12yrs 6 vrs TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ပ ALONZO MAITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a permit. Pages 1 and Department of Health Important: If Imp 27 any injury or other tra Maryland 21229 137 N. Culver St., Baltimore, Dwight Blackwell/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ★XRurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) KING MEMORIAL PARK 12-8-09 BALTIMORE, MARYLAND ral de vil de la constante 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Rollew 1206 W_NORTH AVE., BALTIMORE, MD., 21217 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscleratic Immediate Cause (Final (gralio Vascular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bertension burial-tran Due o or as a consequence of): physician at the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medica examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation s after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours af

To the Funeral Di

completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 553 29b. Signature and title of certifier Amotyn N Nacom Mb

State Registrar

NACEM, 501 32. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day -Tara Physician 3:10 PM Johnson 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** | Kandalistown | | Gunder 24 Hrs. | 8. Date of Birth | Hours | Min. | Month, Day, 10501 Was Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 F 49 219-88-57 (ary and Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 4 es 2 No Funeral Director MUYE 10f. Zip Code 10g. Citizen of What Country Street and Number 21202 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 15 Specify: If Yes, Give Year or Dates: Completed by lack 3 Widowed 4 Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe ဥ 10 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once. niece 6 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12 76 21. Signature of Funeral Service License a 201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-Stage AIDS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate aute the underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Ū Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director page 2 No 1 ☐ Yes 1 □ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 6 Dother specificant hospice Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Many r of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 🗌 No investigation 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00057465 2/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 21136 200, Reisterstown 25 Mainst, Suite Rajapakse M.D N.S Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

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Н	Dhysisia		1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath Dav Yea	3. Time of Death
	Physicia /Medic		Elizabeth M. Johnson			Novemb	er 14, 200	9 11:20 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. County of De	
w.			221 Booth Street 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Gaithersburg If Under 1 Year If Under 24 F	rs. 8. Date of Birt	Montgom	
	Funeral Director		578-40-2122 1□M 2ऱF	89 Yrs.		Dec 18,	1919 Oh	Birthplace (State or Foreign Country) 110
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	Maryl f sho	Ď	MD Montgomery	Cait	hersburg			1 □ Yes 2√□ No
	1 the 1	Director	MD Montgomery 10e. Street and Number	Gare	10f. Zip Code		10g. Citizen of What 0	Country?
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	deat ems	Funeral	11. Marital Status 12. Was Decedent 8	ver in U.S. 13. V	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ar Black, Wh	merican Indian,
326	within 72 hours after death with the Maryland plan. Jen. Than. The Marical Examination and be nother at	by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 N If Yes, Give 3 Widowed 4 Divorced Year or Dates:	0	☐Yes 2∏ No Specify:	iono i noan, oto.,		white
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Š	should I and Men s marke umatic	오	Frank Raymond Moore	105 M-15-	g Address (Street and Number of	11 L. Ho1		7:- O- d-)
, Ma	and 2 st tealth an m 27 is r her traur		19a. Informant's Name/Relationship (Type. Print) William M. Campbell/son		15 Seneca Road			_ :
Baltimore, Mar	of Fig.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State* 4 ☒ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem	sition (Name of latory or other place)	Date	20c. Location - City of	or Town, State
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Superal Service Licensee		: Name and Address of Facilities altimore, MD 21	rd 655 W.	Baltimore	: Street
П			23a. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente		diac or respiratory ar	rest,	Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition	Lodation	ansolo and			Onset and Death
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>	nystci nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	t 3 DOA Other: 4 Nursin	g Home 5 Resid	dence 6 Other (S	pecify)
n oī	ng Pł	L:uo	27. Manner of Death 28a. Date of Injur Natural 5 □ Pending (Month, Day)	28b. Time of Injury	28c. Injury at Work?		now injury occurred	
SIO	tendil eath. or: A the fu	catio	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
DIVISION	al or Att after d I Direct d in by	ertification:	4 Homicide determined 28e. Place of Injubuilding, etc	ry - At home, farm, stre . (Specify)	et, factory, office	28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of and manner sta	examination and/or inv				
	To the within To the Comp	Me	29b. Signature and itle of certifier		29c. License number	l l	29d, Date signed (Mo	
			· CALL	~ D	0326	35	nonewbeu	17,2009
			30. Name and address of person who completed cause of de					
			20 SEAH KARLAN 18111	Prince Pl	rilib Da	olney,	WD SE	0832
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	r's Signature				

■ Baltimore, Maryland 21215-0036

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			State Registrar				Cei	rtificate of	Death		Reg. No.	200	0 0000
	Physici	an	1. Decedent's Nam	e (First, Middle, Las	t)					2. Date of De	Day	Year	3. Tige 800 9110 6
-	/Medi			P.K. John						Novemb	er 12,	2009	1:05 AM M
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	Funeral Director		311-28- Usual Residence o	-3967	M 2□F	79	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Apr 9,	1930	Ill	inois
	yland yland		10a. State	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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	or 28	Pie	10e. Street and Nu					10f. Zip Code			10g. Citizen		ountry?
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920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. I health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mexical Extracting runal be profilled at	by Funeral Director	11. Marital Status1 ☐ Never Marr3 ☐ Widowed	ied 2⊠ Married 4□ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Vas Decedent of I fYes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert Specify:	pecity Yes or No o Rican, etc.)		Race - Ame Black, Whit ecify: wh	
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Maryland	2 sho	100	19a. Informant's N	ame/Relationship (7	ype. Print)			•	t and Number or Ru			wn, State, .	Zip Code)
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Baltimore,	Page nent o ant; If Iry or			position Cremation 3 5 Other (Specify		COL	netery, cren	sition (Name of natory or other pla	ce)	Date	20¢. Locatii	on - Oily or	Town, State
Balt	permit. Departr Importa any inju			ineral Service Licen Onald S	Wade Viy	ector		Name and Addre tate Ana altimore	ess of Facility Litomy Boar L. MD 212		. Balt	imore	Street
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68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list co if any, leading to in cause. Entor Und Cause (Disease or that initiated event resulting in death)	5	cDue to (or as								
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	To the Hospital or within 24 hours after To the Funeral Directory filled in b	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best liner: On the basis and manner si	of examinatio	ledge, deatl on and/or in	occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the	cause(s) and date and pla	d manner a ce, and due	s stated. e to the cause(s)
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_					completed cause of	death (Item 2	23a) (Type, Mu	Print) Counta	- Mill Re	rael,	Reciti	rille	er 11 2009 MD 20855
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per Phy G898 12/07/09 The State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ HNSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Lothian 322 Marlboro Road If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Social Security Number **Funeral** 1 M 2 D F Days Hours Min Jumenth, Pag Year 1928 Macry Tand 81 218-26-8687 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a, State Director 1 ☐ Yes 2X☐ No Lothian Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20711 USA 322 Marlboro Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: white ☐ Yes 2 🔀 No Specify: Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) sanitation commission supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Malvina Virginia Hyde John Herbert Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code 1 322 Marlboro Road Lothian, MD 2071 Betty Johnson/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 X Domation 5 Other (Specify) Signat e I rum rai Service License 22. State Admit Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between
tet and Dest acute Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Zulc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Other (specify) ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practionen To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title o 29d. Date signed (Month, Day, Year) 11/27/2009 HNNPOLIS MALIKO

DHMH 17 Rev 7/2009

State Registrar . Date filed (Month, Day, Year)

32

38690 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30, 2009 **Physician** Neumann Kirkpatrick November 8:45 PM Audrey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛣 F Mar 24. 213-30-3169 80 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County if than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 X No Director MD Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 10718 Potomac Tennis Lane 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No If Yes, Give Year or Dates: Specify Completed by Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withir Health and Mental Hygiene. $5\pm$ Broker Real Estate is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Ernest Neumann Alice Elizabeth Manns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. Jennifer Alice Kirkpatrick/daughter 1905 Abbotsford Dr. Vienna, VA 22182 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Final Journey Crematory 12/04/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** General Debility /Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions Due to for as a consequence of Examiner it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒No Day Month Year 5 ☐ Other (specify) Ö 9 Unknown ۵. signed to be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 autopsy performed? Yes 2 XNo certificate 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ${}_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 ☐ Pending investigation Injury 1 X Natural I hours after death.
uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1. Koucetchou, m) 363742 December 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyn Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#31perDVR. G898.12/4/09 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1) er ember 2, 2009 PAULINE YOUNGUE KENNON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Greneral tospital N/A timore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Year If Under 24 Hrs. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2X F Director 220-20**-**1584 Feb. 4 1929 SOUTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 U.S.A. 1027 CATHEDRAL ST APT 5L Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: BLACK þ 3\times\text{Widowed 4 □ Divorced} Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if Item 27 Is marked other It any Injury or other traumatic event, the Once. 10th grade NURSE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARRIE PERRY MARTIN YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4211 Glenmore Ave., Baltimore, Maryland 21206 Lisa Williams/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 12-04-09 21. Signature of Faneral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final disease or condition resulting in death) **Physician** mic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it are a sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No has 1□ Yes 25. Was case referre medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2M ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 1000 63086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loursette Wega 2120 Baltimore 32. Registrar's Signature

DEC 0 4 200 31. Date filed (Month, Day, Year) State 200 A Carlos Registrar

State of Maryland / Department of Health and Mental Hygiene 2 38692 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 15016117 LOUISE **Physician** INDA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll 502 Dellview Dr. Finksburg 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 64 219-44-6755 1 □ M 2 🖼 F Yrs Director 9-22-1945 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, I've Medical Examiner must be notified at 1 ☐Yes 2√∑No Director Carroll Finksburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Health and Mental Hygiene. 21048 502 Dellview Dr. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Publisher 12 Processor 17. Father's Name (First, Middle, Last)
Walter LeRoy Miller 18. Mother's Name (First, Middle, Maiden Surname) Be Noami Mae Erb ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Dani Knight-daughter 502 Dellview Dr., Finksburg, MD 21048 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place).

Evergreen Memorial 12-7-09 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home D. homas 254 E. Main St., Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the dealt. Do not enter the mode of dying, such as cardischock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. ed by the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No icate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autops certificate 2 [1 ☐ Yes this certific al director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury o the Hospital or Attending Ptithin 24 hours after death.
o the Funeral Director: After the ompletely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who leted cause of death (Item 23a) (Type, Print) uth Couter Stood NOTHINSTER IMD 2115 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38693 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Nonemper **Physician** (atelas PM NNOS 11:0) 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Medical Center Bayview Balt, more 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 ₹ M 2 □ F Months Hours unk 219-82-3144 June 22, 1947 62 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√TYes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 USA 13 Eutaw Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No U 14. Race - American Indian, unk Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 str Department of Health and Important: If item 27 Is n any Injury or other traum Johns Hopkins Bayview Med Ctr 4940 Eastern Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 MOther (Specify) in state 21. Signature (Euneral Selvice Licensee Rona) S. Walt Afrector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final **Physician** Lung CONCEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 🕅 No 1 ☐ Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director; After this certifica 25. Was case referred to medical examiner? director, 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 22 2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3/224 4940 Eastern MI Baltimere, Houston 31. Date filed (Month, Day, Year) Registrar's Signature State 4 2009 0 Registrar

09-08915 Mark Kronman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ark Monnan	1- For State Certificate of Death Reg. No. 2009 386	91
Physician/ Medical Examine		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4d. Aberdeen 4d. County of Death	
Funeral Director	5. Social Security Number 220-46-2334 Table Sex 1. Table Tabl	aign
ow any	Usual Residence of Decedent 10a. State	
eath with the Maryland items 23a or 28a-f show ust be notified at once. uneral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Woodcrest Drive 21001 USA	
r death with the or items 23a must be noti		\exists
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	3 Widowed 4 Divorced in test garden completed) 160 December 1 Specify. White	
5-0036 led within 72 hours after Bygiene. I other than "natural", the Medical Examiner Completed by 1	Elementary/Secondary (0-12) College (1-4 or 5+) 12 2 cable installer Comcast 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
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Physician Lecical	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a, Metastatic Colon Cancer	
/ `xaminer	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
ted hnsit Examiner	if any, leading to immediate Due to (or as a consequence of): Course Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
60, rate be executed hysician and reburial - transit		
ox 687 ath certific attending processes the	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify) 5 Other (Specify)	
P.O. Bc es that the decisioned by the abedetached for the physical by the abedetached for the physical by Physical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and the c	
Division of Vital Records, P.O. lad or Attending Physician: The law requires that the start death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach buffication: To Re Commisted by P.D.	24a. Was an autopsy prior to completion of cause performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	of
tal Recions: The certificate ector, page	by 25. Was case referred to medical 25. Fiace of Death (Crieck Unity Unity)	_
F Vit Physical rathis of	2 1 V Yes 2 No 1 inpatient 2 Exclusive 3 DOA 4 Notice 5 Residence 6 Votal Scale	
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		Oity
To the Hospital within 24 hours a To the Funeral completely filled	Concectifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only only only only and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b Signature and title of certifier 29c. License number O.C.M.E. Dovember 17, 2009	
	3b. Nume and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2230PM MARY E KOENIG 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HUWARD HOWARD LOUNTY GENERAL HOSPITAL COLUMBIA 8. Date of Birth (Month, Day, Year) Jan 29, 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🛛 F 1923 Iowa 474-18-4084 Director Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hyglene. Prise marked other than "natural", or items 23a or 28a-f show traumatic event, Is. Medical Expirition and the inciting of the property. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No MD Director Howard Columbia 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21044 5400 Vantage Point Road #106 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: white Be Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 nurse healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental E.
Important: if then 27 is mediany injury or other 1. Alf Fredrick Berg Mary Elizabeth Rohleder ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5014 Paducah Road College Park, MD Elizabeth Scribner/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licensee Konaly S Wade Wrector Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or c d ion resulting in deal) **Physician** espirato May /Medical Due to (or as a consequence of): Examiner neuman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.O. 1 1 Yes 2 ON 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 Wo certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier , MD, FCCP 236845 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man-Clin nayyen, 140, MD 2106 Columbia, arale 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			For State	State of Mary		artment of I <i>rtificate of</i>			iene _{eg. No.} 2 ()	ηq	38696
			Registrar 1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat		0)	3. Time of Death
	Physici	an						Month	Day 21 20	Year	1622 M
	/Medio		4a. Facility Name (If not institution, gi	KIOWELL		4h City Town o	or Location of Death		4c. County		1000
	Examir	ner	Harbor	11	1 1	P.			io. county	or Boutin	
			5. Social Security Number Unk 6.	HOSPIT	yrs. last birthday)	If Under 1 Year	Itumo If Under 24 Hrs.			9, Birthpl	ace (State or Foreign
	Funeral Director			M A OF F	8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 21	Year)	Coun	
	Director		Usual Residence of Decedent		0	L		Julie 21	, 1741		
	land ow		10a. State 10b. County	100	. City, Town or Lo	ocation				10	d. Inside City Limits
	Mary f sh	ō	MD		Balti	more					1∏Yes 2□No
	the 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Count	ry?
	with Sa or		111 Park Avenue			212	201		II	SA	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Exan in terms to be multised at	Funeral	11. Marital Status unk	12. Was Decedent Ever	in U.S. 13.		Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-		e - America	an Indian,
`	riter in	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No				Rican, etc.)	Blac	k, White, e	tc.
Š	al", o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:		Specify	whi	te
0000-0	2 hou	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation	unk	16b. Kind of Bu	siness/Ind	ustry unk
-	within 72 iene. than "na "	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	n kind of work done DO NOT use retire	during most of worked)	aing			
7	y with	Į,	unk	unk			_				
2	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the fedical Experience west be realified at	Be C	17. Father's Name (First, Middle, Las	1)		unk	18. Mother's Nam	e (First, Middle, N	Maiden Surnan	ne)	unk
Jana	ould be I Mental narked o	10 E									
<u> </u>	shou ind N	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Stree	t and Number or Ru	ral Route Number	r, City or Town,	State, Zip	Code)
2	nd 2 alth a 27 is r tra		Harbor Hospital		3001	S. Hanov	ver Street	: Baltimo	ore, MD	212	25
הַ ע	permit. Pages 1 and 2 should be Department of Health and Mentis Important: If item 27 is marked any Injury or other traumatic es once.		20a. Method of Disposition	2	0b. Place of Dispo	osition (Name of matory or other pla	100)	Date	20c. Location -	City or To	wn, State
altillore,	age ent o it: if y or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Spec	Removal from State	cemetery, cre	matory or other pla	1				
=	artme		The second secon	ncon // //	2	2. Name and Addr	ess of Facility				-
0	Department of the permit of th	ļ	21. Signal in al Funeral Sorvice Los	Wade, Nirec			ess of Facility Comy Board		Baltim-	ore S	treet
	431	-	23a. Part 1. Enter the disease, or cor	polications that caused the	death Do not en	altimore,	MD 2120	or respiratory arm	est		Approximate
			shock, or heart failure. List only	one cause on each line.	death. Do not en	_		or respiratory and	001,		Approximate Interval Between Onset and Death
\ I	Physician	ı	Immediate Cause (Final disease or couli ion resulting in death)	a. Caro	lac	Arres	t				
ď	/Medical Examiner		Toolang in doubly	Due to (or as a co	•	2040 3022 .	í.	^	Part of the Co.	£ 10000	
	LXUIIIIICI		Sequentially list conditions,	. Diab	etic Ki	etoacu	dosis i	craq	ragolu	hy_	
	ed sit	Examiner	Sageentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co			1	100	•		
	and tran	(aπ	that initiated events resulting in death) Last	c. Due to (or as a co		lled	diabe	TEZ		-	
Š	icate be executed physician and the burial-transit		, , , , , , , , , , , , , , , , , , , ,	Due to (or as a co	isequence oi).						
	ate the physical the p	dical		d							
5	entific ing p	Mec	IF FEMALE:								TV - C
200	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pour 1 ☐ Live birth 2 ☐		☐ Ectopic pregnan	icy			te of delive	ry Day Year
	e dea ed fo	sici	1 □Yes 2 □No	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5	Other (specify)	-		141	2000	Day (Cai
	at the I by t	h	9 Unknown			_					
ກົ	e law requires that the de has been signed by the je 2 should be detached	by	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying cause gi	iven in Part I.				e cause of death?
necolds,	quire en si uld b	ed			<u>-</u>			1 □ Ye	es 2 No	3 ☐ Prob	ably 4 dnknown
2	law re as be 2 sho	Completed						24a. Was a	n 24b.	Were auto	psy findings available npletion of cause of
č	slcian: The la certificate ha irector, page 2	E						autops	med?	death? 1 ∐Yes	
	an: 7 tiffica or, pa		25. Was case referred to medical				26 Place of Dea	1 ☐ Yes		TLITES	2 10 100
	Physician: this certific ral director,	Be c	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA Ot	her:	ome 5 ☐ Reside		ner (Specifi	v)
5	ding Physician: n. After this certific funeral director,	Ë	27. Manner of Beath	28a. Date of Injury	28b. Time of	of 28c. Inju	ury at	28d. Describe ho			,,
5	ding h. Afte	Ę.	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ar) Injury		ork̃? ⊒Yes 2 ⊡No				
0	dear dear ctor y the	lica	3 Suicide 6 Could not	28e. Place of Injury -	At home, farm, st	reet, factory, office		28f. Location (St	treet and Numi	ber or Rura	l Route Number,
DIVISION	after Dire T in b	Certification: To	4 ☐ Homicide determined	building, etc. '(S	pecify)	2/		City or Town	n, State)		
	pital ours eral filled		29a. Certifier 1 Certifying F	hysician: To the best of m	v knowledge, dea	th occurred at the	time, date and place	and due to the o	cause(s) and m	anner as s	tated.
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical		miner: On the basis of exa							
	o the ithin o the omple	Me	29b. Signature and title of certifier			29c. Licer	nse number	2	29d. Date signe	d (Month,	Day, Year)
	F>Fŏ		177	0	O(DIV	1) 0	CC ^^		11/0	100	3
•				one	× (167-	<u> </u>	C>00	1	11100	10	1
-			30. Name and address of person who	0 0		Print)	Brook	I	(IL	212	76
			31. Date filed (Month, Day, Year)	3001 S +	an ove	JT.	Dr.DOK	yn "	٧)	212	03
	Sta Rogista		nco 0 4 2009	A	A 1300	100		-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	,	epartment of Certificate of		Reg.	No. 2009	38697
	Physicia /Medic		1. Decedent's Name	e (First, Middle, Las	ANOR	K	APLO	W	2. Date of Death Month NWEMBER	Day 7, 200	3. Time of Death 9 5-18 P M
	Examin				street and number)	-hinatan		or Location of Death ville		4c. County of Dea	
<i>y</i>	Funeral Director		5. Social Security N 500–46–	umber 6. Se	reater Was	(In yrs. last birth		If Under 24 Hrs.	8. Date of Birth (Month, Day, Young) Sept 29,	ear) 9. Bii	rthplace (State or Foreign ountry)
	/land		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ba-f sh	Director	MD	Montgo	nery	Rocl	cville				1 □Yes 2√ No
	with th	Dire	10e. Street and Nur	mber ntrose Roa	a d		10f. Zip Code	20852	10g	. Citizen of What C USA	ountry?
36	i within 72 hours after death with the Maryland jene. Jene. r than "natural", or items 23a or 28a-f show the Medical Eventhale must be mortified at	by Funeral	11. Marital Status	ied 2□ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 📉 N If Yes, Give	Ever in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- pecify Rican, etc.)	14. Race - Am Black, Whi	
15-0036		Completed b		15. Decedent's Ed cify only highest grad			Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	upation e during most of worl ed)	king 16	b. Kind of Business	s/Industry unk
212	filed within Hygiene. other than '	Som	Elementary/Seco	ndary (0-12)	College (1-4or 5- 5+	+)	social work	cer			
ng ng	be d d	Be		(First, Middle, Last)	_				ne (First, Middle, Ma. Levinoff	iden Surname)	
Maryland	d 2 should be th and Mental 7 Is marked of traumatic ev	၉		A. Travin		19b.	Mailing Address (Stree			City or Town, State,	Zip Code)
	trai			Eigles/da			729 Evenin				21044
Baltimore,	jes 1 t of H If iter or oth		4 X Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	20b. Place of cemetery	Disposition (Name of , crematory or other pla	i	Date 20	c. Location - City o	r Town, State
Rall	permit. Pag Department Important: any Injury once.		21. Sign yure R	onald S.	Din	etor	22. Name and Addi State A: Baltimo	natomy Boa	ard 655 W. 1201	. Baltimr	oe, Street
1	Physician /Medical		23a. Part 1. Enter t shock, or hea Immediat. Cause disease or resulting in death)	art failure. List only ((Final	a. A P	AL 1		LATIC	2/1/	t,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions,	b. 551V	a consequence of	DEI	MEN	TIB.		
,	ificate be executed g physician and as the burial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death)	erlying injury s Last	c Due to (or as	a consequence o	f):				
98760	icate b physic the bi	edical		•	d						
O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnat 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
ds, P.	uires that t n signed by lld be deta	þ	Part II. Other signi	ficant conditions c	ontributing to death bu	ut not resulting in	the underlying cause g	given in Part I.	23e. Did toba 1 □ Yes	:/_	to the cause of death? Probably 4 Unknown
Vital Records,	The lar ate has page 2	Completed							24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
Vita	Physician; r this certific ral director,	Be	25. Was case referexaminer?	,	Hospital:				ath (Check onl. one)		
-	Sir b	n: To	1 ☐ Yes 2 ☐ 27. Manner of Dea	th	28a. Date of Inju	ry 28b. T	ime of 28c. Inj	4 ∟rNursing F	lome 5 ☐ Residen		pecify)
Division of	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	1	5 Pending investigation 6 Could not be determined				ork? □Yes 2□No e	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
<u> </u>	Hospital 24 hours a Funeral E	Medical Ce	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examination an	, death occurred at the d/or investigation, in my	time, date and place y opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within To the compl	Me	29b. Signature and	y tile of certifier	o Li	closus	29c. Lice	nse number 3543	6 No	d. Date signed (Mo.	nth, Day, Year) 2 ZY, 200P
			BANUAN	ress of person who	completed cause of d	eath (Ham &a) (MUNITEDS!	TRD, R	eckul	15, MD	28,2008 20852
ı	Sta Regist		31. Date filed (Mor	Th, Day, Year)	9 3. Registr	ar's Signature	park				

DHMH 17 Rev 1/2001

Registrar

1 - For State Registrar 38699 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 420 A M **Physician** ROBERT C. KRAFT 30 11 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Square Hospital Center Rosedale FRANKLIN 8. Date of Birth (Month, Day, Year) NOV • 5 • 19 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 □ F 212-36-8680 71 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director BALTIMORE MD NOTTINGHAM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3811 GLENVIEW TERRACE 21236 USA ", or items 23a c aminer must be by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or iter edical Examiner and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo WHITE Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) PRINTER PRINTING Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland CHRISTIAN F. KRAFT ELLEN E. BENTE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MERLITA KRAFT-WIFE 3811 GLENVIEW TERRACE BALTIMORE, MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD 12/5/09 ATLANTIC CREMATORY 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final obstructive pulmonary Disease **Physician** Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ArTer diseas Coronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affer 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D63054 November 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms, 9000 Franklin Square Drive, Baltimore, MD 21237 Majid 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

AaFT

			For State	State	of Marylar		artment of F	lealth and N		iene eg. No. 20	09	38	700
			Registrar 1. Decedent's Name (First, Middle	, Last)			tinoute or i	Douth	2. Date of Deat			3. Time of	
	Physici		Nancy J.Lee	, , , , ,					Month December	3 2009	Year	4:54	a.M
	/Medic Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	r Location of Death	AND AND AND AND AND AND AND AND AND AND	4c. County	of Death		C. *
	Examin		10519 Marriottsvil	le Road			Randal	lstown		Bal	tinore	1	
П	Funeral			6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State o	or Foreign
	Director		056-28-6647	1□M 2ÅF	/9	7 Yrs.	MOITINS Days	Hours Will.	5-27-193)		RI	
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation				110	d. Inside C	ity Limite
	sho	ō		ltimore	100. 01		dallstown					1 □Yes	
	the M	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/hat Count		
	be filed within 72 hours after death with the Maryland tal Hygiene. did Hygiene. did chher than "natural", or items 23a or 28a-f show event, Ital Madical Expelled man the profiled at	al Di	10519 Marriottsvi	lle Road			21133	3	'	USA	Tiat Count	.,,.	
	ems ems	Funeral	11. Marital Status	12, Was Dec Armed F	cedent Ever in U	.S. 13.\	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		e - America k, White, e		
36	s afte	by Fu	1 Never Married 2 Marri	ed 1 Tes If Yes, G	2∭No aive		Yes 21∑No	Specify:	,		Cauca		
21215-0036	hours tural	q pe	3 ♥ Widowed 4 □ Divorced	Year or I	Dates:	160 Door	lant's Havel Ossue	otion		16b. Kind of Bu			
5	in 72 "na" r	Completed	15. Decedent (Specify only highes	t grade completed	 	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of work	king	160. Kilia di Bu	SITIESS/ITIU	ustry	
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Ö	e filed al Hygi other vent, II	Be C	17. Father's Name (First, Middle, L	_ast)		_ I RATE AND	JI COL	18. Mother's Nam	e (First, Middle, M	-			
au	2 should be fi and Mental H Is marked of raumatic eve	To B	Andrew MacPhail					Margaret	McLav				
Maryland	2 should and Mer Is marke raumatic	-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	-	; City or Town,	State, Zip	Code)	- 1
_	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Carl W. Lee/Son			1805 I	Bahama Road	, Lexington	n, Kentucky	40509			
altımore,	es 1 a of He of He item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place	re)	Date	20c. Location -	City or Tov	vn, State	
Ĕ	Pages ment of ant: If it ury or o		X□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		i State I		emorial Gdn		= 09	Eldersbu	g, MD	1	
ă	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service L	icensee	1.1		. Name and Addre		lie Funera		.A. of	Baltin	pre Co.
מ	20 E # 9		Mandon	111, W	ylu	92	200 Liberty	Road, Rand	allstown,	MD 21133			
			Ba. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximat Interval Bet	tween
and a	Physician	1	Immediate Cause (Final disease or condition	- Pa	rkins	on's	dise	ase			12	Onset and	veurs
3	/Medical Examiner	10	resulting in death)	Due to	o (or as a conseq	uence of):							
u	LXUIIIIIei	<u>.</u>	Sequentially list conditions,	b									
	red isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseq	uence or):					-		
_	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c	o (or as a conseq	uence of):							
8/60,	icate be executed physician and the burial-transit	dical E		d									
	ificate g physi ss the t	edic		Q									
X R R	requires that the death certifi been signed by the attending hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		1			23d. Dat	e of delive	ry	
מ	death e atte	icia	in the past 12 months? 1 □Yes 2 ☑No	4 □ Pre	e birth 2□Feta gnant at time of o] Ectopic pregnanc] Other <i>(specify)</i> _	y 		Moi	nth I	Day	Year
5	t the by th tache	hys	9 □ Unknown	9 □ Unk	nown								
'n.	ss tha gned se del		Part II. Other significant condition	-	death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to the	e cause of o	death?
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<u>r</u>	Physician: The law r this certificate has tal director, page 2 sl	Ę							perforr	ned? c	leath? □Yes	-	
VItal	cian; ertific sctor,	Be (25. Was case referred to medical examiner?					26. Place of Deat	th (Check only on	e)			
5	hysi this c		1 ☐ Yes 2 ☑ No		Inpatient 2			4 LI Nursing Ho	ome 52 Reside)	
ב ב	ing F After uner	ion:	27. Manner of Death 1 Natural 5 □ Pending	(Mo	e of Injury nth, Day, Year)	28b. Time of Injury	Worl	< ?	28d. Describe ho	w injury occurre	∌d		
200	ttend Jeath tor: , the f	cat	2 Accident investiga 3 Suicide 6 Could n	ot bo	a of labour AA la			Yes 2 □No	201 1			(Double Mari	-
DIVISION	or At after of Direct in by	Certification: To	4 ☐ Homicide determine	ned 28e. Plac build	ding, etc. (Specif	ome, rarm, stre	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	er or Hurai	Houte Nun	iber,
_	spital lours neral		29a. Certifier 1 Certifying	Physician: To th	ne best of my kno	wledge, death	n occurred at the tir	me, date and place	, and due to the c	ause(s) and ma	anner as st	ated.	
)	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only	yaminer: On the	hasis of examina	tion and/or in	vestigation in my c	minion death occur	rrad at the time d	ate and place a	and due to	the cause(s	s)
V	vith Voith Com	Σ	29b. Signature and title of certifier		ma		29c. Licens	e number	2	9d. Date signed	(Month, E	Day, Year)	. 0
			> sough	n	1.00		De	57827	D	ecembe	r 4	, 20	109
			30. Name and address of person v	who completed cau	se of death (Item	n 23a) (Type, I	Print)	e number 35844 Cad Sui	te 10x	Rand	allsto	wn 1	no
	Sta	te	31. Date filed (Month, Day, Year)	000	Registrar's Signa	ture /	Alas 1		0		4 1 0	2.1	133
	Registra	ar	DEC 0 4 2	DUD KK	man 6	· July con							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 4c, per MD g898 12/4/09 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar 38701 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 11 4:05 PM Charles 9009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner U. 5.17 of Maryland Haspital Baltimore Oniversit Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months ★ M 2 F 65 218-42-9269 Director 23,1944 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at N/ABaltimore 1X Yes 2 □ No Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 2255 W. Baltimore Street 21223 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black ō 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, IT Magnes. Private Industry Construction Unk. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Lipsy William Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5603 Old Court Rd Baltimore, Maryland 21244 Yvette Lindy/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition King Memorial Park 11-30-09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of uneral control be-5240 Reisterstown Rd Baltimore, MD 21215 arra Approximate Interval Between Onset and Death Za. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imperiate Cause (Final Isease or condition resulting in death) Bespirator Physician /Medical Due to (as a consequence of): Examiner Primary Lunes Sequentially list conditions, if they reading to humanistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of): tending physician ar use as the burial-P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Dav 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Yes 2 No 3 Probably 4 Unknown concer Pron Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an page 2 autopsy performed? 1 □ Yes 2 No certificate I ospital or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 31 Ironwood Circle Norlin BEAT Registrar's Signature 31. Date filed (Month, Day, Year) State 2009 4 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lendza December 8:58 A M Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk 7864 Charlesmont Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, January 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Maryland Days 1 □ M 2 🔽 F Months Hours "16",1935 212-30-7978 74 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Director 1 Yes 2 XNo Dundalk Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21222 7864 Charlesmont Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 - Widowed 4 - Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hour artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natuinjury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Housewife 8 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elsie Ruth Frank A. Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 21222 7864 Charlesmont Road, Dundalk, Maryland Husband Algird Lendza 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 Burial 2 Carcemation 3 Removal from State Baltimore, Maryland Bayview Crematory 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) er mit. et art my or ny inj Signature of Juneral Service License Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to performed 1 ☐ Yes 2 XXNo after death.

Director: After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 $\sqrt[4]{}$ Residence 6 \square Other (Specify) 2 **N**No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 29c. License number D45530

State Registrar 9114

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASALLAM

·SW

31. Date filed (Month Day

Baltimose

Philadelphia soad,

				Plea	se Type or Pr					-		gible.	
			For State Registrar		State of N	/laryland		artment of I rtificate of I		Mental Hy	/giene Reg. No. 2	nna	20703
	Physicia Medi		1. Decedent's Name		,					2. Date of D Month Dec	eath	00 [°] 9 ^{ar}	3. Time of Death 12:03A M
	Examin				give street and number) Hospice			4b. City, Town, o	r Location of Deat	h		nty of Death	·e
	Funeral Director		5. Social Security N 248 . 42 .	umber		ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi		9. Birthr	place (State or Foreign
	show at	jo.	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation	·				Od. Inside City Limits
	B Maryla 28a-f	Director	MD	i	imore	Tow	son						1 🗆 Yes 2 No
	with the	Funeral D	10e. Street and Nun 1 Ruxv		t. Apt. 20)2		10f. Zip Code 212(04		10g. Citizen o		ntry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortany injury or other traumatic event, the Medical Examiner must be notified at once.	5	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 ⊠ Marr	12. Was Decedent	t Ever in U.S		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		pecify Yes or No o Rican, etc.)	- 14. F	lace - Americ Black, White, Gify: Wh	
15-0	72 hour n "natu Aedical	Completed		cify only highe	t's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done O NOT use retired)	during most of wor	king	16b. Kind of	f Business Inc	dustry
1212	d within ygiene.	Be Cor	Elementary/Second 12		College (1-4 or	5+)		w Rider			Eques		1
Baltimore, Maryland 21215-0036	d be filed Mental H arked ot atic ever	To B	17. Father's Name (i	First, Middle, L		nk			18. Mother's Nar Blancl	ne (First, Middle ne Pic		me)	
Mar	Ith and Ith and Ith and Ith and Ith Ith Ith Ith Ith Ith Ith Ith Ith Ith		19a. Informant's Na					ng Address (Street uxview (
ore,	ye 1 and it of Hea if item or othe		20a. Method of Disp	oosition	3 Removal from Stat	_ ce	ace of Dispo	osition (Name of	ce)	Date	20c. Location	on - City or To	own, State
altim	mit. Pag partmen portant: / injury		4 ☐ Donation 21. Signature of Fu			- X		aké Crer 2. Name and Addre		.04.09 FA/Ste			rmannPA
ä	Depar Depar Impor any in		36	las	complications that cause	in .		8717 Gr	een Pas	tures	Dr. Ba	lto.	, MD 21286
	Pnysician/ Medical Examiner			rt failure. List o Final	a. DEMENT Due to (or as	ne.		ar the mode of dyn	ig, such as cardiac	or respiratory a	irest,		Approximate Interval Between Onset and Death
	e executed cian and urial-transit	al Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmediate rlying ilinjury s	b. Due to (or as								
68760	ih certificate be tending physicii or use as the bu	Medic	IF FEMALE:		d								
Box	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the b	Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	су			Date of delive Month	ery Day Year
ds, P.O.	requires that to been signed be should be deta	b	Part II. Other signif	icant conditio	ns contributing to death	but not resu	ulting in the u	ınderlying cause gi	ven in Part I.	- 1			ne cause of death?
of Vital Records,	sician; The law re certificate has be irector, page 2 sho	Completed								perf 1 Yes	s an 24 opsy ormed? 2 X No		psy findings available mpletion of cause of
Vital	ysician; is certific director,	To Be	25. Was case referre examiner? 1 Yes 2	ed to medical No	Hospital:	itient 2 🗆 E	ER/Outpatie	26. P	er: 4 Nursing F		idence 6 🕱 C	ther (Specify	HOSPICE
n of	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 2 Accident	5 Pendin			28b. Time of injury	work	y at		how injury occi		
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Certificate:	3 Suicide 4 Homicide	Investig 6 Could r determi	not be 28e. Place of Ir	ijury - At hor tc. (Specify)	me, farm, str	eet, factory, office	1100 2 2 3 110		(Street and Nun wn, State)	nber or Rural	Route Number,
	Hospita 24 hours Funeral eted filled	Medical	(Check 2	Medical E	Physician: To the best of kaminer: On the basis of Nurse Practioner: To the	examination	and/or inves	tigation, in my opini	on, death occurred	at the time, date	and place, and	due to the cau	use(s) and manner stated
	To the vithin To the compl	2	29b. Signature and		ANT	e best of my	Kilowiedge,	29c. Licens		- and due to t	29d. Date sign		
1				l _	who completed cause of	`	, , , , ,	,	m Transie		1000	-1-1	
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	Registr	ar	- DE	C 0 4 21	NY Sterling	1 13.	ben						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ Mario T:00A M 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care -Baltimore Chemi Wood storstown 6. Sex 1 \(\text{M} \) 2 \(\text{F} \) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 021691163 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important If firem 27 is anarked other than "natural", or items 23a or 28a-f sho may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No JUVIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nobvor 12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Seconday (0-12) College (1-4 or 5+) Social Morkey Maryland 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ orence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eslie Lewis Croudon Road GWINN Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Baltimore, MD altimore National Donation 5 D Other (Specify) C. Greene Furtal Services Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugno Road Randailstown MD 21133 Approximate Interval 3-tween set a Death 23a. Part 1. Enter the illisease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest shock, or he 13 illure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🖪 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? certificate 25. Was case referred to predical 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 5 Pending (Month, Day, Year) 1 Natural work?
1 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the i 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Laycock Dec. 3:00p M Donald Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard Glene1g 3789 Ivory Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ፟ M 2 □ F Mar. 30 69 Months Days Hours Year 1940 528-48-5811 Utah Director Usual Residence of Decedent a or 28a-f show be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Glenelg 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 3789 Ivory Road 21737 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 No be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White Year or Dates. 65-67 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cardiopulmonary Technician Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John D. Laycock Bernice Louise Decker . Page 1 and 2 should tment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Owsik/Friend 3789 Ivory Road Glenelg, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Metro Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Dec 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Cremation Society of Maryland, 299 Frederick Road Baltimore, Maryland 21228 Alice Iser Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MULTIFORME J410BLASTUMA Physician/ months disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 481 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 2 XNo မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RNP

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

R097025

1550 ORLEANS ST, CRB 2,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20ሽ 2:00 p M Dec Michael Levine Samue1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 28 Cockeys Mill Road Reisterstown Baltimore 5. Social Security Number g. Birthplace (State or Foreign Country District of Columbia If Under 1 Year If Under 24 Hrs Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 AM 2 □ F Days Hours Months July 1. 579-46-6811 1937 Yrs Director 72 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Maryland Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? Funeral 28 Cockeys Mill Road 21136 United States or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", 3 Divorced Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) Hygiene. College (1-4 or 5+) the Realtor Real Estate traumatic event, Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked of 2 Oscar Levine Mitzi <u>Clipker</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Starrla K. Levine/ Wife 28 Cockeys Mill Road, Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oti December. 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2009 Baltimore, Maryland Metro Crematory. Inc 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ MINASTATU L disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death Month Day Year detached the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by ed bluods 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 🗌 No Yes 2 X No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5🗶 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 3850C bec 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas Koutrelates 10710 Charter Cokembia MARY LAND Dowe

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:15 A M December 2009 Heino Meigo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Days Min 1 🛛 M 2 🗆 F Estonia Director 91 1918 142-26-5710 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Baltimore MD 10f. Zip Code 23a or 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a o Funeral 21206 USA 4501 Forest View Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 K No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates er than "natura", the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin any injury or other traumatin and injury or other Elementary/Seconday (0-12) College (1-4 or 5+) Horticulture Horticulturist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Malvine Roigas Aleksander Meigo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 Forest View Ave. Baltimore, ND 21206 Helmi M. Meigo/wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 12/04/09 Woodbine, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final URA Physician/ runths disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner nontre -ALL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying physician and s the burial-transit Cause (Disease or linjury that initiated events law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the g Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 2 No Hospital or Attending Physician: The certificate 1 ☐ Yes 2 X No 1 Yes After this certification Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOS 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending September 172009 UNKARUN M death. Investigation Accident ** within 24 hours after death

To the Funeral Director: of the completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 4501 FOREST VICH AV, BALTMONE NO) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29d. Date signed (Month, Day, Year) 29c. License numbe December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHALLES MO 6701 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 4 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2009 38708 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 30, **Physician** 2009^{ar} Donald J. McCrorv 11:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore 8. Date of Birth (Month, Day, Year) Aug. 08, 1918 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min. Mary Land 1**X**) M 2□ F 214-01-1069 Director 91 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at MD Baltimore Director Parkville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8820 Walther Blvd. U. SA. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 3altimore, Maryland 2121 Elementary/Secondary (0-12) State of Maryland College (1-4or 5+) nd Mental Hygiene. marked other than Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Albert McCrorv Anna Rachel Dailev McCrory, ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9840 Old Willow Way, Ellicott City, MD 21042 Dennis McCrory/ Son Department of Health Important: If item 27 any Injury or other trong. 27 20b. Place of Disposition (Nam 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 12/05/09 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timoni um, MD 4 ☐ □ Qonation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 2 a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediale Cause (Final isease or condition r sulting in death) Cardiomyogathy Physician 1-Schemic /Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.O. ed by the detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Evascular Complications 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy Division of Vital 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending ours after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide hours within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R171944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8832 Walther Blvd, Bockville MP 21234 Micheau ...
31. Date filed (Month, Day, Year) G Harrison CKNP

DHMH 17 Rev 1/2001

State

Registrar

DEC 0

11/30/09

Donald

32. Registrar's Signature

			For State	State	of Maryl	and / Depa	rtment o	of Health of Death	and M			009	387	09
			Registrar 1. Decedent's Name (First, Midd)	le, Last)			imodio	or Dout	, 	2. Date of Dea	Reg. No. ath		3. Time of De	eath
	Physicia		Joseph James M	ariano, S	sr.					Nov.	30 ^{Day}	200 ^{Year}	6:20	Рм
	/Medio Examin		4a. Facility Name (If not institution	n, give street and n	umber)	-	4b. City, Tov	n, or Location	of Death		4c. C	ounty of Death		
			1406 Joppa Forest					oppa				Harfor	-	
	Funeral Director		5. Social Security Number 215–30–8280	6. Sex 1 XX M 2□ F	7. Age (In)	yrs. last birthday) S Yrs.	If Under 1 Y Months D	ear If Unde ays Hours	Min.	8. Date of Birt (Month, Da April 19	h Ye <i>ar)</i> 193:	9. Birth Cou Ma	place (State or F ntry) ryland	Foreign
-	р		Usual Residence of Decedent										and tractal and	1.2
	show	٥	10a. State 10b. County	ford	10c.	City, Town or Lo	cation J opp	a					10d. Inside City 1 ☐ Yes 2	
	the N 28a-f	rect	10e. Street and Number				10f. Zip Co				10g. Citize	en of What Cou	ntry?	
	h with	al Di	1406 Joppa Fore	st Drive, A	pt. P			21085			τ	United St	ates	
215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, it is it stook from the results of the describing at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☒XXivorcec	ried Armed I	2 □ No Bive	1	Vas Decedent f Yes, specify I □Yes 2【X	Cuban, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.	
ۍ ص	72 hor	eted	15. Deceder	nt's Education est grade completed	f)	16a. Dece	dent's Usual C	ccupation one during mo	ost of worki	na	16b. Kind	d of Business/Ir	dustry	
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ק ס	filed Hyg ther int,	ပ္ပိ	12 17. Father's Name (First, Middle,	Last)		<u> </u>	Inspecto		her's Name	(First, Middle,			Cultury	
yland	ould be a Mental arked o atic eve	To Be	Michael Maria							Caramanio				
Zaz	she man		19a. Informant's Name/Relations David L. Mariano -							al Route Numbe		Town, State, Zi 3. 21122	p Code)	
ore,	es 1 and 2 of Health s if item 27 is or other tra		20a. Method of Disposition	2 Demoval from	20	b. Place of Dispo cemetery, cren akeview M	sition (Name on atory or other	of place)	С	ate	20c. Loca	ation - City or T	own, State	
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g n	permii Depar Impor any ir		21. Signature of Funeral Service	Licensee	ut	22	Evans Fu 3800 Han	ddress of Faci neral Ch ford Roa	apel & d, Pari	Crematic kville, M	n Serv Brylar	vices — P nd 21234	arkville	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause or	caused the d each line.	leath. Do not ent	er the mode o	f dying, such a	as cardiac o	or respiratory a	rrest,		Approximate Interval Betwee Onset and De	
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Ī	be sit	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		U (01 as a cuit	sequence of j.	1						15 yr	
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VItal	Physician: this certific ral director,	Be (25. Was case referred to medica examiner?						ce of Death	(Check only o	ne)			
5	Physic r this cral dire	To:	1 ☐ Yes 2 🗖 No 27. Manner of Death		npatient 2	2 ER/Outpatier		Other: 4 🗆 I		me 5 Residence 128d. Describe I		Other (Spec	ify)	
0	nding ath. r: After	ation	1 X Natural 5 ☐ Pendii		onth, Day, Yea		M 200.	Work? 1 □Yes 2 [Zog. Describe i	iow injury	cocurred		
UIVISION	al or Atte atter des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	minod 200, Flat	ce of Injury - A ding, etc. (Sp	At home, farm, str pecify)	eet, factory, of	fice		28f. Location (S City or Tov	Street and vn, State)	Number or Ru	al Route Numbe	9 <i>r</i> ,
	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: After completely filled in by the fune.	edical (ing Physician: To t i Examiner: On the and ma										
	To th withir To th comp	Me	29b. Signature and title of certific	er			29c. L	cense number	r		29d. Date	signed (Month	, Day, Year)	
			* King &	(26		MD		3109	13		12/	1/09		
			30. Name and address of person	,	use of death	(Item 23a) (Type,	Print)	1	0.64	115	m 100	2		
	Sta	te	Nancy E. 1095. 31. Date filed (Month, Day, Year,		Registrar's Si	DPFH+A ignature	MKI	> 10	PPA,	NID .	2102	5>		
	Registr		DEC 0 4 200	19 /	2 1.	Marko	19							

	٦	-	For State of Ma State Registrar	•	partment of F <i>ertificate of I</i>			2009	38710
			Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia		ANNIE	me DON	ALD		November		a 1209 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	4	c. County of Deat	n
			MORTHWEST HOSPITAL		RAN	PALLSTOW	~	BALTINO	QF
Т	Funeral			je (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birti Co	hplace (State or Foreign untry)
	Director		212-28-1263 1□M ¾F	8 4 Yrs					G.Carolina
	pu »	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			•	10d. Inside City Limits
	aryla sho	ō	N/A	Balti					1,□Yes 2□No
	the N	ect	Maryland 19/74 10e. Street and Number		10f. Zip Code		10g. f	Citizen of What Co	untry?
	with Sa or	0	2117 Penrose Avenue		212	23		USA	
	death with the Maryland rms 23a or 28a-f show	Funeral Director	11 Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Ame	
0	riter of		Armed Forces? 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No			Rican, etc.)	Black, White	
200	be filed within 72 hours after death with the Marylan Hygiene. 4 other than "natural", or items 23a or 28a-f show event, the Macincal Examiner must be notified at	ğ	3 Widowed 4 □ Divorced Year or Dates:		1 □Yes 2√□No	Specify:		Specify:Bla	ack
5-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup live kind of work done le. DO NOT use retire	ation during most of work	ina	Kind of Business/	•
7	ithin ne.	du du	Elementary/Secondary (0-12) College (1-4or s		^{fe. DO NOT use retire} I shier	d)	1	ltimore	_
.V	ed w lygiel her th		12th grade		ISIITEL	19 Mothor's Name	Puk e (First, Middle, Maid	olic Sch	nools
and	be fill hall had out	B	17. Father's Name (First, Middle, Last) Mack Gredg				e Scott	en oumanie,	
5	2 should be and Menta is marked aumatic ev	은		10b M	ailing Address (Street			v or Town State	Zin Code)
Mar			19a. Informant's Name/Relationship (Type. Print) Claudia Russell/ Daught		8 Arlene				
	1 and Health tem 27		20a, Method of Disposition		isposition (Name of crematory or other pla			Location - City or	
<u></u>	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	177777471	crematory or other pla Ridge Ce:	metery 12,	75/09 20c. Pik	esville	Maryland
altimore,	permit. Pages Department of Important: If i any injury or once.		4 □ Donation 5 ☑ Other (Specify) Entomb 21. Signature of Funeral Service Licensee	ment	_	, –	1		neralHome
ñ	permit. Departr Importa any inju		Non Harris	9	5240 Rei	stersto	wn Road 1	Baltimo:	re,Md21215
			23a. Part1. Enter the disease, or complications that cause	d the death. Do not					Approximate Interval Between
3	Physician		Shock, or heart fallure. List only one cause on each limmediate Cause (Final		orogan marketine o				Onset and Death
No. of Lot	/Medical		resulting in death)	a consequence of):	ert duca	24			
	Examiner		b						
V.	p #	ner	cause. Enter Underlying	a consequence of):					
D.	ecute ind trans	Examine	that initiated events c.						
/60,	be ex ician a burial-		Due to (or as	a consequence of):					
8	sate ohys	dical	d						
×	ding se a	Physician/Me	IF FEMALE: 23c. If yes, outcome	e of pregnancy				23d. Date of de	livery
Box	atter for u	ian	in the past 12 months?	2 Fetal death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)			Month	Day Year
O	the di yy the iched	ıysi	1 ☐ Yes 2 MNo 4 ☐ Pregnant 3 9 ☐ Unknown 9 ☐ Unknown						
1	requires that been signed b nould be deta		Part II. Other significant conditions contributing to death I	but not resulting in th	ne underlying cause gi	ven in Part I.	23e. Did tobaco	co use contribute to	o the cause of death?
<u>5</u>	quires n sign ald be	d by					1 ☐ Yes	2 □ No 3 □ P	robably 4 🔀 Unknown
Records,	e law requires that the de has been signed by the je 2 should be detached	Completed					24a. Was an		utopsy findings available
	The law cate has b page 2 sf	E O					autopsy performed 1 □ Yes 2 🔀	? death?	completion of cause of
	ilcian: The certificate ector, pag	BeC	25. Was case referred to medical			26. Place of Deat	th (Check only one)	ino i i i i i i	22110
	Physician: r this certific ral director,		examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpat	ient 2 ER/Outp	atient 3 DOA Ot	her: 4 🗆 Nursing He	ome 5 Residence	e 6 □ Other (Spe	ecify)
_	TD (D) (D)	Ë	27. Manner of Death 1 1 ☑ Natural 5 ☐ Pending (Month, D.	ury 28b. Tin ay, Year) Inju		ry at	28d. Describe how in	njury occurred	
<u> </u>	Attending ir death. ector: After by the fune	atic	2 Accident investigation			Yes 2□No			
Division of	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 28e. Place of In building, e	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Stree City or Town, S		ural Route Number,
	pital o		29a. Certifier 1 ™ Certifying Physician : To the bes	t of my knowledge	heath occurred at the	time, date and place	and due to the caus	se(s) and manner a	as stated.
	P Hos 24 hc Fun etely	Medical	(Check only 2 Medical Examiner: On the basis one)	of examination and/	or investigation, in my	opinion, death occu	rred at the time, date	and place, and du	e to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Me	29b. Signature and title of certifier		29c. Licen	se number	29d.	Date signed (Mon	th, Day, Year)
			1 Trayednek ins			D005973	26 n	oventer	27, 2009
	6		30. Name and address of person who completed cause of						
	-								
	Sta		DEBORAM WATSS FITZEA 31. Date filed (Month, Day, Year) 32. Regist	trar's Signature	no M	IR TITHEST	HUSSITAL	5401	OUP LOVET ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Helen V. 30, 2009 3:30 P Miner November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5408 Highridge Baltimore Halethorpe Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 XF Months Days Hours Min 220-36-1952 70 6-06-1939 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Expirity must be purified at anones. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Halethorpe Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5408 Highridge, Street 21227 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HealthCare 12 Medical records 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Griffith, Sr. Ruth P. Yeager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 Highridge Street, Halethorpe MD 21227 Ronald G. Miner/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial | Dec.4,2009 | Halethorpe MD Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus MD 21227
Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approx Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** enal disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner burial-trar Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown icate has been signated by page 2 should b 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Nesidence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death.

Director: Af filled in by 24 hours a completely within 2 the

Baltimore, Maryland 21215-0036

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Bruadway, Baltmore MD arclucci MD Michael

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

82. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2^y009 Physician/ McCormack racqueline C. Dec. 7:23P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Center 9. Birthplace (State or Foreign . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 04.19.1948 1 M 2 Hours 61 218.46.6236 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Phoenix MD 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21131 14108 Fox Manor Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 within 72 hours after 1 Yes 2 No If Yes, Give Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Public School Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary G. Morgan John Edward McCormack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Teeter 14108 Fox Manor Lane, Phoenix, MD 21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2. Cremation 3 Removal from State 12.08.09 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 14014 22. Name and Address of Facility CAFA/Stephen D. LohrmannPA 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive, Balto., MD 23a. Part DEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Uterine Physician/ CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 use as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has to page 2 s autopsy perform After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 2 Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) +6 Sp 16 2 💢 No 1 Yes ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural iniury 5 Pending death. 2 Accident
3 Suicide n 24 hours after death.

e Funeral Director: A leted filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 3, 2009 R149194

Registrar
DHMH 17 Rev 7/2009

State

N. Charles St

32 Registrar's Signature

Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grant

4 2009

31. Date filed (Month, Day, Year)

6701

09-09277		Please Type or Print in Black Indelible Ink. Ensure All Copi		egible.	
Diana Lynn Moses		State of Maryland / Department of Health and Mental F	Hygiene	2009	3871
	F	- For State Certificate of Death legistrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No.	Time of Death
Physician Medical Examine	~	1) .		Day Vear	0000 hrs
modical Examina		4a. Facility Name (if not institution give street and number) 4b. City, Town, or Location of Dea		4c. County of Death	
,)		1341 Hill Born Drive Hanover		Anne Arundel	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M		Birth(MM/DD/YYYY) 9. Birthpla Foreign	ace (State or
Director		531-82-6331 1 M 2 F Yrs. Months Days Hours M	11-1	2-1965 Country	Germany
	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		100	d. Inside City Limits
ow any				1	Yes 2 No
ryland	핡	MD <u>Ginne Grundel</u> Hanover 10e. Street and Number		10g. Citizen of What Country?	?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f show al Examiner must be notified at once.	Director	134/ Hill Bus Drive 21076		USA	
with t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Indian, Black,
death	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No	rto Rican, etc.)	White, etc.	aV
after al", o	S S	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: D/A	
2 hours after "natural", Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life DO NOT use not seem to the contract of the contr	etired)	16b. Kind of Business/Indu	stry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Human Resource	- M C	Vantact (Services
15-0036 filled within 7 l Hygiene. ed other than t, the Medica	탉	17. Father's Name (First, Middle, Last) 18. Mother's Nam	me (First, Middl	e, Maiden Surname)	- 6111-0
21215 uld be file Mental H. marked o	ga Pa	David E. Franklin Meli	55a (rooden	
22 ould d Me	٥	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route	Number, City or Town, State, Zip	Code)
e, MD 1 and 2 sh Health and Fitem 27 it		Cilenn D. Mos es/Husband 1341 Hill Born J	Date	20c. Location City or Tov	91019
or He	-	20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, Femalory or other place) Removal from State	Date -	200. 200. 200.	
Page ment tant:		4 Donation 5 Other Specify: CRWnSVINE 16	1-1-09	1 Crownsy	illemo
Baltimore permit. Pages 1: Department of H Important: If it injury or other t		21. Sign ture of Fugeral Service Licensee 22. Name and Address of Facility	ughh (C. Greene Fun Pike Batto.n	HALL SCHICE
Physician	-	23a. Part I. Efter the disease, or corplications that caused the death. Do not enter the mode of dying, such as cardiac failure. Let only one cause on each line.	c or respiratory	arrest, shock, or heart	Approximate interval
/Medical	Į,	0 - 11			Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrnythmia Due to (or as a consequence of):			
		Sequentially list conditions, b. Cardiomegaly		4	
	Examiner	if any, leading to immediate Due to (or as a consequence of):		-6	
J8	Xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
xecuted I - trans	calE	d			
be exusician	影	X UNPENDED AMENDED PI line a-b, 27, perME ,g899	1/28/10	TT	
Box 68760, te death certificate be executed the attending physician and edfor use as the burial - transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	23d. Date of delivery Month Day	Year
x 68 h certi tendin use a	흲	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Box e death c the atten	hys	1 Yes 2 No 9 🗸 Unknown g Unknown		id tobacco use contribute to the	anuse of death?
that th	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Yes 2 No 3 Probab	
tal Records, P.O. B cian: The law requires that the d certificate has been signed by the ector, page 2 should be detached					sy findings available
ord tw req as bee	Completed		_ a		pletion of cause of
Rec The la	팃		1 🗸 Y	es 2 No 1 Yes	2 No
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of Vital Records, ing Physician: The law require Affer this certificate has been si uneral director, page 2 should be	٥	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nu	rsing Home 5	Residence 6 Other: S	cene
n of ding Ph.h.	ë	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	200. 2000.	iso non injery course	
ivision or Attene after death Director:	cati	2 Accident Investigation 28e Place of Injury - 4t home farm street factory office building etc.	28f. Location	on (Street and Number or Rural	Route Number, City
Division ous aftendir ous after death. filled in by the fur	Certification:	3 Suicide 6 Could not be determined (Specify)	or Tov	vn, State)	
Hospital 24 hours Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and manner as stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the burian directory.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, o	date and place, and due to the o	cause(s)
E & E 8	₩	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	
		Mh Sravel Mo		November 30, 200	9
d		30. Name and address of person who completed cause of death (Item 23a)	4D 24204		
\mathcal{V}		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	/ID 2 1201		
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Apark			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per Fh g898 12/9/09 TT
State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12 - 2 -^{Day} 2009 10:25A M Gloria Miller 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Golden Living Center Westminster 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 - 9 - 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 ☒ F 095-18-4198 84 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No MD Carroll Taneytown 10g. Citizen of What Country? 10e. Street and Number 17 Bowie Mill Ave. 10f. Zip Code 21787 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Banking Banker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louis Greenstein Minerva Berkovitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 Bowie Mill Ave., Taneytown, MD 21787 Cary Miller-daughter Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 12-4-09 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee 254 E. Main St., Westminster, MD 21157 Konnas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lelasta disease or condition resulting in death) Sequentially list conditions, and, leading to in reclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 X No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

Completed by Funeral Director

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Itam 27 Is marked other than "natural", or Itama 23e or 28e-f show any nigury or other traumatic evant. The Medical Evarifiest must be notified at once.

Baltimore, Maryland 21215-0036

with the Maryland

Physician/Medical Examiner The law requires that the death certificate be executed physicien and the burial-transit Box 68760,2 use as for P.O. signed t Records, þ cate has been sig , page 2 should b Completed certificate Division of Vital Be 2 this Certification: After death.

the Hospital or Attanding Physician: Director: filled in by 24 hours a completely

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Natural 1 🗌 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

within 2

ddress of person who completed

w cause of death (Item 23a) (Type, Print)

D254 Rd, Westminstor,

State Registrar

ical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08826 State of Maryland / Department of Health and Mental Hygiene 38715 2009 Robin Lynn Marble Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 12, 2009 Physician/ 1020 hrs **Medical Examiner** Robin Lynn Marble 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Goerges Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 110 6. Sex **Funeral** Min Months Davs Hours Director Feb 19. 1964 Country) 45 1 M 2 XF Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No Capitol Heights Prince George's 28a-f show MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medix-al Examiner must be notified at once. rector 10g. Citizen of What Country? 10e. Street and Number USA 20743 1 Cindy Lane #204 ۵ 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral unk 12. Was Decedent Ever in U.S. White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes Specify: white Yes 2 X No specify: Yes, Give Year Divorced 3 Widowed 4 2 unk 16a. Decedent's Usual Occupation (Give kind of work done UNK 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD111 Penn Street Baltimore, O.C.M.E. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State ment tant: or of in state Donation 5 X Other Specify: 21. Signature of Funeral & ryice Licensee Ronal Q S Wade 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street MD Raltimore. Approximate Interval 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and List only one cause on each line Death Medical a.Pnemococcal meningitis Immediate Turise (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical XUNPENDED AMENDED the attending physician ed for use as the burial -23a,27,perME, g898 12/28/09 TT The law requires that the death certificate be Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 V Unknown <u>S</u> Completed icate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? After this certificate has ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other; Residence 6 Other: Hospital: 1 Inpatient 2 Nursing Home 5 ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca

Hospital or Attending Physician: 24 hours after death Funeral Director: After this certificately filled in by the funeral director, I within 2 To the I

> Assistant Medical Examiner asto

and manner stated

30. Name/and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 14, 2009

State

Registra

29b. Signature and title of certifie

Melissa Brassell, MD 31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Miller 2340 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 9. Birthplace (State or Foreign Country) unk Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 X Months Hours Min. Sept 7, 7ay, Yang 39 Director 220-68-7208 70 Usual Residence of Decedent 28a-f shov ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 Yes 2 No Millersville MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 USA 899 Cecil Avenue unk 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 18886 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the unk unk Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Department of Health and Ment, Important: If item 27 is marked any injury or cat. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Washington Med Ctr Hospital Drive Glen Burnie, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) In State Signature - Euneral Service Licensee State Anatomy Board 655 W. Baltimore Street Baltimore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death ATHEROSCIEROTIC CARDIOVASCULAR DISCASU Physician/ disease or con-Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and-tran Due to (or as a consequence of): the burialattending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day the detached 9 🗌 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; performed' this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29b. Signature 29c. License number NOVEMBER 24, 2009 D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD, BALTIMIRE, MD 21236 ·WALLACE, MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** MARY E. OHMAN 2009 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Rosedale Franklin UG uare +Imore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-18-1948 9. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday **Funeral** Days Months 1 □ M 2 K F 61 Director 439-80-9193 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2√TvNo Director Baltimore County Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21236 USA 65 Powderview Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes X2X No If Yes, Give Year or Dates: 1 Never Married 20X Married じんかみの ///a と対 Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CXNo Specify White Specify: þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than 'ratural', any injury or other traumatic event, I'm Medical East Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Homemakina Elementary/Secondary (0-12) College (1-4or 5+) 2 vrs. Own Home 12 yrs. Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Elberson William Keith Faulk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 65 Powderview Ct. Baltimore, Maryland Ohman (Husband) Jon. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition **X**□ Burial 2 □ Cremation 3 □ Removal from State 12-9-2009 Baltimore, Maryland Moreland Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 any ir Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** peritonea Tro /Medical Due to (or as a consequence of): Examiner nerea 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of): attending physician for use as the burial Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown iis certificate has been s director, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 9000 Fran

32. Registrar's Signature

Ke300000

12.03.2009

Square Dr Baltimore, Md 21237

Maliniu Alex, M.D

31. Date filed (Month, Day, Year)

DEC 0 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 63748

	1	For State Registrar	State	of Marylan		artment of F		nd Mental H	lygien Reg. N	000	9	38719
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/Medica Examine		4a. Facility Name (If not institution (*PESCENT	give street and n			4b. City, Town, or	Location of			c. County o		GEORGE'S
Funeral Director		5. Social Security Number 679–20–1970	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	8. Date of (Month, Mar.	Day, Year)	Cour	place (State or Foreign htry) chington, DC
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to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 [☑ No 9 □ Unknown	1 ☐ Liv	outcome of pregna e birth 2□Feta egnant at time of d known	I death 3	☐ Ectopic pregnanc ☐ Other (specify) _	;y		_	23d. Date Mor	te of delivery onth Day Year	
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		30. Name and address of person ALLEN BAL	MHER , M.	D_ 4L	lug El	Print) AST - WEST	HIGHE	114, 1	RIVER	PALE,	MAN	1L4VD
Stat Registra		31. Date filed (Month, Day, Year) DEC 0 4		Registrar's Signa	ture &	affect				,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

Director

Funeral

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Examiner

Completed by Physician/Medical

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Certification: To

Medical

Amirali Nader,

31. Date filed (Month, Day, Year)

Funeral

Director ral", or items 23a or 28a-f show The Medical other than 2 should be fill and Mental h permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any linjury or other traumatic en once. item 27 is marked other traumatic en

Pase of Medical Sca Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and the al or Attending Physics after death.

Il Director: After this ed in by the funeral d filled in by

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1. Decedent's Name (First, Middle, Last) 2. Date of Death DAVID 11:16 AM ALLEN PERKINS 29, November 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Suburban Hospital Bethesda Inder 1 Year | If I Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 1 ☎ M 2 ☐ F Months Days Hours Min. 284-36-5171 12, 1939 70 Nov. Ohio Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1x Yes 2 No Belmont Ohio <u>Barnesville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 West South 43713 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 TM Married 1 Tyes 2 No. ģ Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver School System 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Hatcher Clyde Perkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 West South Barnesville, Ohio 43713 19a. Informant's Name/Relationship (Type. Print) Carolyn Perkins - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Assumption Cemetery Dec.3, 2009 | Barnesville, Ohio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kelly-Kemp-Braido Funeral Home 702 East Main Street, Barnesville, OH Part t∮Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory failure 24-48 hrs disease or condition resulting in death) Due to (or as a consequence of): Pneumonia 48-96 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Tyes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature 00065123

Registrar DHMH 17 Rev 1/2001

State

23rd Street NW, Washington, DC 20037

7 *mo*

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

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901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician/ $11^{\text{Month}}_{-29} - 200^{\text{Day}}$ 1150 P M Delila Juanita Perticone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill 200 Clifford Lane Apt M If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 11-29-1977 Min. 1 □ M 2 🕅 F 82 WV Director 577-40-0780 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 Ves 2 No Forest Hill Harford MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò event, the Medical Examiner must be Funeral 23a 21050 USA 200 Clifford Lane Apt M items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Social Security Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Essie V. Hawk Henry E. Rohrbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Theodora Ct Forest Hill, MD 21050 Ronald Pertizone (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11-03-2009 Holly Hill Cemetery Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Sig a) re of Funeral Service Linensee Schimunek Funeral Home of BelAir O MacPhail Rd Bel Air, MD 21014 610 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 25 piranon Medical Examiner Securitially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the sid be detached f g Unknown q Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bv 1 🗌 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an B Hospital or Attending Physician: The law r 124 hours after death. The Funeral Director, After this certificate has I be Funeral Director, After this certificate has I autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 2 No 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dex To the Funeral Director completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif

State Registrar 31. Date filed (Month, Day, Year)

1205

32 Registrar's Signature

398 Lutherville MD 21093

m.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38722 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2/25M 1,63714/ Nov 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death, 4c. County of Death Examiner Schulban Box to s (31) SA 62 4 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | I 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 € M 2 □ F Months Massachussetts **,** 1928 81 293-22-1743 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MD Bethesda Montgomery Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 United States 9707 Old Georgetown Rd. Apt.1414 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 9 1 □ Yes 2 X No Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iva Stone Jerome Preston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. 9707 Old Georgetown Rd. #1414 Bethesda, MD 20814 Ravida K. Preston (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 1 ☐ Burial 2 ី Cremation 3 🗀 Removal from State Chesapeake Crematory 2009 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Intracere /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events mo Examiner physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): 68760 CPhysician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) s been signed by the should be detached □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⚠ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? Yes 2. K. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1XYes 2 □ No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. 1 Natural Injury 5 ☐ Pending investigation within 24 hours arter .c...
To the Funeral Director: Aff Hom Kits Walking 1 ☐ Yes 2 🗷 No 1130 M 2 Accident 3 ☐ Suicide No1 27 2009 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown reeL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

P.0. Records, Vital Division of

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State Registrar DHMH 17 Rev 1/2001

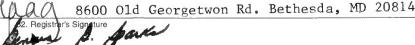
4 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who contaleted cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title



29c. License number

29d. Date signed (Month, Day, Year)

09-09201	
Ronald Paul	II

onald Paull		State of Maryland / Departme For State Certifications	ent of Health and Mental Hy ate of Death	giene 	No. 200	9 3872		
Physiciar Medical Examin	1/	Decedent's Name (First, Middle,Last) Ronald Keith Paull, Jr.		2. Date of Death Month Date November 26	y Year 5, 2009	3. Time of Death 1358 hrs		
	•	la. Facility Name (if not institution, give street and number) 14910 Vintage Lane	4b. City, Town, or Location of Death Old Town		4c. County of Death Allegany			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. Yrs.	8. Date of Birth (F	MM/DD/YYYY) 9. Bir Foreig L 986 C	thplace (State or in ultro)rida		
w any		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town				10d. Inside City Limits		
with the Maryland ns 23a or 28a-f show be notified at once.	Director	MD Allegany 0	10f. Zip Code	ľ	Citizen of What Cou	ntry?		
with the last 23a or be notifie		14910 Vintage Lane , SE 11. Marital Status 12. Was Decedent Ever in U.S.	21555 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer White, etc.	ican Indian, Black,		
er death	by Funeral	1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Pates:	If Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 X No specify:		Specify:	White		
6 n 72 hours an "natur ical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retin	ed)	6b. Kind of Business/			
21215-0036 Uld be filed within 72 Mental Hygiene. Thank other than 'te event, the Medical		11	Installer 18.Mother's Name Kimber			ioning		
MD 2121! d 2 should be fill lth and Mental H n 27 is marked numatic event, t	To Be	19a. Informant's Name/Relationship (Type, Print)	bb. Mailing Address (Street and Number or R 4910 Vintage Lane, S.	Rural Route Number	er, City or Town, State			
		1 X Burial 2 Cremation 3 Removal from State crema	of Disposition (Name of cemetery, latery or other place) owridge Mem. Pk. 12-		Coc. Location - City of Elkridge,			
Baltimore, permit. Pages 1 a Department of the Important: If ite injury or other to		21. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the death. Do n	22. Name and Address of Facility Gar	y L. Kau	fman Funer	al Home at		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line. Immediate Cause (Final disease a. Asthma	not enter the mode of dying, such as cardiac o	r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death		
xaminer		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,						
		if any, leading to immediate cause. Enter Underlying Cause (Ussass of hijury that hattated events resulting in death) Last Due to (or as a consequence of):						
te be executed ysician and e burial - transit	ledical Ex	d	27 not ME (202 12/10/	00 тт				
ox 6876 eath certifica attending ph	AMENDED 23a, PII, 27, per ME G898 12/10/09 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a, PII, 27, per ME G898 12/10/09 TT 23d. Date of del Month Pregnant at time of death 5 Other (Specify) 9 Unknown 23d. Date of del Month							
P.O. B		Part II. Other significant conditions contributing to death but not resulting ng in the underlying cause given in Part I.		o the cause of death?				
cords, P	Completed by			24a. Was ar autopsy perform	prior to death?			
n of Vital Recing Physician: The After this certificate funeral director, page	Be Co	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 EP/6	26.Place of Death (Check	only one)	esidence 6 🗸 Oth			
ion of Vi tending Physi eath. tor: After this	의	1 Ves 2 No Imparent 2 Environment 2 Environm	Outpatient 3 DOA Outlet 4 Nursit Time of Injury 28c. Injury at Work? 1 Yes 2 No	3	w injury occurred	er. Scene		
Division spital or Attuburs after de meral Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City		
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and rinvestigation, in my opinion, death occurred	d due to the cause at the time, date a	nd place, and due to	the cause(s)		
F 3 F 3	M	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (November 27,			
	Ì	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 1) 11 Penn Street, Baltimore, MD 212	201				
Sta Registi	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
DHMH 17 Rev 1/20 OCME 2006	01	OCME	MAL					

DHMH 17 Rev 1/2001 OCME 2006

OCME

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Amend #5, per Fh 9898 12//09 TT
State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 Picka11 Medical Ann Dec 6:50p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Thompson Street Anne Arundel Annapolis 0 \$00 all \$ecurity Number 040 - 0705574 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔯 F Months Days Hours Connecticut Director Yrs une Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2😾 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Thompson Street United States death v , or items 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural", White 3 X Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 5+ Schools .ibrari*a*n Be Page 1 and 2 should be filed of ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bruns Medlev traumatic Barbara Chelke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Roger Pickall/Son 115 Chapel Road, Faston, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 2. 1 Burial 2 🔀 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Baltimore, Maryland Metro Crematory, Inc. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21,228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** uns Sequentially list conditions, if any leading to in the Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Duinto (or as a no been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy performed? death? Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signatup title of certific 29d. Date signed (Month, Day, Year) D.00185-29 30. Name and ad npleted cause of death (Item 23a) (Type, Print) 0 2009 Tidewater Colony Drive, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38727 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernadine Louise Ritter December: 2009 6:30 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 18, 1930 212-28-1927 1 □ M 2 🗓 F Days Hours 79 Director Mary land Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits death with the Maryland Director MD Baltimore Parkville 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 2445 Ellis Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 2 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 1 No Specify: White If Yes, Give Year or Dates Specify: "natural", Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AT&T Telephone Operator Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Raymond James Maurer Martha Anne O'Nester Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9401 Armada Way, Baltimore, MD 21237 Warda Sampedro/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/03/09 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Evans Afrantia Chapel & Cremation 8800 Harford Road, Parkville, MD at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line. ediate Cause (Final Physician/ div ase or condition sulting in death) hemic Medical Due to (or as a consequence of): Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Year Dav the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Res 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 🗆 No 1 🗌 Yes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medical **Division of Vital** To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No MOSPLU 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

State

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVES

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32. Registrar's Signature

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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09-09175									
Dina Lynn	Rice								

Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Decedent's Name (First, Middle,Last)								
Physician 1. Decedent's Name (First, Middle,Last) 2. Date of Decedent's Name (First, Middle,Last) Medical Examiner Dina Lynn Rice	Day Year 1455 hrs							
Medical Examiner Dina Lynn Rice November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death							
6226 Lone Oak Dr #239 Bethesda	Montgomery							
Funeral Director 5. Social Security Number(Int) 6. Sex 1. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of B Months Days Hours Min. 3/25/3	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) DC							
Usual Residence of Decedent	10d. Inside City Limits							
MD Montgomery Bothords	1 Yes 2 XX No							
Toe. Street and Number 10a. State MD Montgomery 10c. City, Town or Location Bethesda 10c. Zip Code 10f. Zip Code 20817	10g. Citizen of What Country?							
ង ទី ទី	USA							
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify:	o- 14. Race - American Indian, Black, White, etc.							
The state of the s	Specify: White_							
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry							
15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)								
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The second of th								
Joan M. Rice, mother 6226 Lone Oak Dr. Bethesda,	MD 2081 / 20c. Location - City or Town, State							
2 X Cremation 3 Removal from State Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Crematory or other place) Chesapeake Crematory 12/1/2009								
4 ponation 5 Other Specify: CITES a peaker Creditatory 12/17/2009 21. Superture of Funery Septice Lio M01539 22. Name and Address of Facility Rapp Funer								
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Physician /Medical 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a failure. List only one cause on each line.	rrest, shock, or heart Approximate Interval Between Onset and Death							
Immediate Cause (Final disease or condition resulting in death) a. Oxycodone Due to (or as a consequence of):	7 2000							
Sequentially list conditions, if any, leading to immediate b								
if any, leading to immediate cause. Enter Underlying Cause (Clasass or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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9 and the state of	23d. Date of delivery							
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O the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of death? es 2 No 3 Probably 4 V Unknown							
The law requires from the law requires to the	s an 24b. Were autopsy findings available prior to completion of cause of							
Per Co O D D D D D D D D D D D D D D D D D D	formed? death? 2 No 1 ✓ Yes 2 No							
Yes 25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other; Nursing Home 5								
1 ✓ Yes 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes 2 No 1 ✓ Yes 2 No 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury (Month, Day, Year) 28. Time of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work?	Residence 6 Other: Scene e how injury occurred							
So to the second								
Natural Suicide Homicide	(Street and Number or Rural Route Number, City State) 6226 Lone Oak Dr							
4 Homicide determined (Specify) Found: residence #239 Be	ethesda, MD							
29b. Signature and title of certifier 29c. License number	e and place, and due to the cause(s)							
29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)							
hy hu, ws O.C.M.E.	November 26, 2009							
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State 31. Date filed (Months Pay, Year) 2009 32. Fegistrar's Signature								

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		•	For State Registrar			•	Cer	tifica	te of L	Death		Reg. N	∞ വ വ വ	3 3 6	729
			1. Decedent's Name	e (First, Middle, La	ast)	-					2. Date of D	of Death 3. T			e of Death
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	Examin		4a. Facility Name (if 101 Graf	_	e street and number)	4b. City, Town, or Location of Death Rosedale					4c. County of Death Baltimore			
	Funeral Director		5. Social Security Nu 215~30~7	umber 6.	. 🗆	nge (In yrs. I	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min.	5. 8. Date of Birth 9. Bi 6. (Month, Day, Year) C 2-7-1934			Birthplace (Sta Country) Maryla:	nte or Foreign
			Usual Residence of	Decedent											
	aryland a-f sho fied at	ector	Maryland	Baltimo	re	10c. Cit	ty, Town or Lo		e Cou	unty					e City Limits Yes 2XXNo
	ith the M 3a or 28 t be noti	Funeral Director	10e. Street and Num	nber		1			ip Code	21237		10g. C	Citizen of What (Country?	
	ems 2	nue	101 GIGI	COII CC.	12. Was Deceden	t Ever in U.	S. 13. V	Vas Dec	edent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No)-	14. Race - Ar	nerican Indiar),
936	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F		ied 2 ☐ Married	Armed Forces 1 Yes XX If Yes, Give Year or Dates					an, Mexican, Puer Specify:	to Rican, etc.)		Black, Wh		
2-0	hours natur dical b	olete	(Spe	15. Decedent's cify only highest of	Education	'	16a. Deced	lent's Us	ual Occup	ation during most of wo	rking	16b.	Kind of Busines		
121	thin 72 ane. than '	Som	Flementary/Second 12 yrs.		College (1-4 o	r 5+)	life. D	O NOT u	se retired)	aum g moot or mo	9	Stee	el Comp	anv	
d 2	filed within al Hygiene. d other tha	Be	17. Father's Name (F				1 71000	01102	5	18. Mother's Na	me (First, Middle			<u></u>	
/lan	d be fi Menta arked artic ev	10	John B.	Rott						Doroth	y Fox				
Aan	of and 2 should be file of Health and Mental F fitem 27 is marked of r other traumatic ever		19a. Informant's Na					-					y or Town, State, Zip Cod		
e, N	and 2 Health em 27 ther t		Charles 20a. Method of Disp		(Son)	20b F	Place of Dispo			Ct. Bal-	Date	Maryland 2		21237	
Baltimore, Maryland 21215-0036	¥ + - 0		1 ☐ Burial 2X		Removal from Sta	to C	ro Cre	natory or	other place		5~2009		timore,		
Ball	permit. Pag Departmen Important: any injury:		21. Signature of Fur	122. Name and Address of Facility Lassahn Funeral Home 17401 Belair Rd. Baltimore. Md. 21236											
			23a. Part 1. Enter the shock, or hear	he disease, or coi t failure. List only	nplications that caus one cause on each I	ed the deat ine.						•		Approx Interval	Between
~	Physician/ Medical		Immediate Cause (I disease or conditio resulting in death)		a	Ct								Onset a	nd Death
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70	executed ian and irial-transit	Examiner	Cause (Disease or that initiated events resulting in death) L	3	C. Due to (or a	s a consequ	uence of):								_
		dical		•	d										
	law requires that the death certificate be has been signed by the attending physici e 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 1 9 Unknown	montbe?	23c. If yes, outcom 1 Live Birtl 4 Pregnan 9 Unknow	n 2 🗌 Feta t at time of o	al death 3 🗌	Ectopic Other (су			23d. Date of o	delivery Day	Year
, P.O.	es that th signed by I be detac	by	Part II. Other signif	icant conditions	contributing to death	but not res	sulting in the u	nderlying	g cause giv	ven in Part I.			use contribute		_
ords	w requir s been s s should	Completed				,					24a. Wa		24b. Were	autopsy findir o completion	ıgs available
Rec	The lar	Som									per	formed?	/ death	? /es 2 🗆 No	_
taj	ician: The certificate ector, pag	Be	25. Was case referre examiner?		Hospital:					ace of Death (Che	eck only one)				
Ξ	ding Physician: h. After this certific funeral director,	To	1 Yes 2	1 100	1 🗆 Inpa		ER/Outpatier 28b. Time of		DOA Oth	4 ☐ Nursing	Home 5 Res			ecify)	
o uc	nding ath. r: After e fune	icate	1 ☑ Natural 2 ☐ Accident	5 Pending Investigation	(Month, E	Day, Year)	injury	М	work		20d, Describe	now my	,		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of I	njury - At ho etc. (Spec <i>if</i>)	ome, farm, stre	eet, facto	ry, office		28f. Location City or To		nd Number or f e)	Rural Route N	umber,
_	e Hospit 24 hour e Funera deted fille	Medical	(Check 2	Medical Example Medical Exa	ysician: To the best niner: On the basis o rse Practioner: To the	examination	n and/or invest	tigation, i	n my opinio	on, death occurred	at the time, date	and plac	e, and due to th	e cause(s) and	l manner stated.
	To th Withir Comp	_	29b. Signature and	title of cortifier				29	c. License			29d. D	ate signed (Moi)
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_	6		ROH	17 GUL		37	730 F	rint)	· Ro	10, 3.	17, MO	12	no	2/2	1)
	Sta Registra		31. Date filed (Month	4 2009	32. Regis	trar's Signa	ture	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) GORDON **Physician** November 2009 12:01a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Summit View Nursing Home Catonsville
If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stare Country)
Sept. 22, 1918 Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1**X** M 2 □ F 91 Director 216-07-2850 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1603 Edmondson Ave. Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify Specify: White ≥ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than "natul traumatic event," 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Ritter ပ Anna R. (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a John Corbitt (Per. Rep) 105 N. Rolling Rd., Catonsville, MD 21228 t other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory
@ Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ţ, Department of Important: If It any Injury or conce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12/3/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 3 Probably 4 donknown 1 🗌 Yes 2 □ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Hospital within 24 hours a the

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

Bipin K.

Turkhia

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

November 30,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 mith Medical CVRMIA 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Izabeth Ursing Cent 1 Mert Funeral Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min. Director 219-18-6577 84 12-30-1924 Country) MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Elkridge 1 ☐ Yes 2🌠 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6391 Rowanberry Drive Apt. #325 21075 **USA** 12. Was Decedent Ever in U.S. 43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1946 Specify: White 1 ☐ Yes 2 X No Specify "natural". Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Foreman Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည George M. Smith Sr. Josephine Diederich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6391 Rowanberry Drive Apt. #325 Elkridge MD 21075 Helen M. Smith - wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 a Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Atlantic Crematory 12-3-2009 Glen Burnie MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Tome 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician Onset and Death disease or condition resulting in death) monom elle Medical Due to (or a a consquence of): Examiner 5 Truction iarl month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence if) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Day Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed?

1 Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗌 No မှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? Accident Investigation 2 🗆 No 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 200 vember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320

State

Registrar

MD

31. Date filed Morth, Day, Year)

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Registrar's Signa

venue

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month AM 2009 renne DECEMBER 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth 09.19.1971 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) MD 38 215.11.4569 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Tes 2 No MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2428 McCulloh 21217 Street Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mass Transit Elementary/Secondary (0-12) 12 College (1-4 or 5+) Administration Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gloria Lyndall Jennings Kenneth Adolphus Richards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 1966 Milton, WA 98354 Gloria Jennings/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12.04.09 Beltsville, MD Chesapeake Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. LohrmannPA 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive, Balto., MD 23a. Part 1 Sinfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at once.

attending p been signed be should be def this within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	resulting in death)	a											
dical Examiner													
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	opic pregnancy er (specify)		23d. Date of delivery Month Day Year								
Completed by Physician/Medical	Part II. Other significant conditions of	contributing to death but not resulting in the under	lying cause given in Part I.		o use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \)								
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edical		ysician: To the best of my knowledge, death occurrence: On the basis of examination and/or investige and manner stated.											
Ž	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)								

Registrar

State

31. Date filed (Month, Day, Year)

FIONA HAVERS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

125-000

Decomber 2,2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08854 2009 38733 State of Maryland / Department of Health and Mental Hygiene Anthony Swann 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2230 hrs Medical Examiner November 14, 2009 Anthony Swann 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital STU 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min Director Country Maryland 215-90-9299 1 X M 2 F 45 July 16, 1964 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location Ę 10a, State 10b. County 1 X Yes 2 No nt: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once. MD Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10g, Citizen of What Country Directo 10f. Zip Code 10e. Street and Number 21201 USA 855 Lemmon Street Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married Yes Specify: black Give Yea Widowed Divorced Yes 2 X No specify: <u>ج</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 disabled none 0 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margie Sampson æ Clarence Swann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 19a, Informant's Name/Relationship (Type, Print) 871 W. Lombard Street Baltimore, MD Terry Woods/sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) Burial 2 Cremation 3 Removal from State mportant: 4 X Donation 5 Other Spects 9 21. Signature of Euneral Service Ronald W. Baltimore Street Board 21201 22. Name and Address of Facility 655 'n e∕¢tor Baltimore, MD 23a. Part | Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and List only one cause on each line /Medica Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED certificate has been signed by the attending physician a ector, page 2 should be detached for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' 1 🗸 Yes Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26 Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other₄ Hospital: 1 Inpatient Nursing Home 5 Residence 6 ER/Outpatient 3 ဥ 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27, Manner of Death Subject shot Nov 14, 2009 1414 hrs Natural Pending Yes 2 ✔ No filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 855 Lemmon Street, Baltimore, MD determined (Specify) Single Family 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. November 15, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar

09-08658 Arvel Simpson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vel Simpson		St 1- For State	ate of Maryla				and	Menta	al Hy	giene		2 (201	2 0	077
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Physicia Iedical Exami		Arvel Sim							- 1	Month	Dav	y Year	ı l'	1051	
		4a. Facility Name (if not institution		ımber)	4	b. City, Tov	vn, or Lo	cation of		TTOVCITIE		4c. County of	Death		
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Funeral		5. Social Security Number	6. Se x	7. Age (In yrs. I	ast birthday)	If Under		If Under	_	8. Date of	Birth (M	M/DD/YYYY)	9. Birth Cour		te or Foreign
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1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 X Other Specify in state Metro Crematory 11/27/2009 Catonsville, N									. MD						
Baltimore, permit. Pages I an Department of He Important: If ite	1	21. Si mature of Funeral Sarvice		hreatur	22. N	ame and Ad	dress o	f Facility]	Park	er F.	н.	3512 F	rede	rick	Ave
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Box e death the atte ed for u	ysi	1 Yes 2 No 9 Un	known 9 Unkno		5 Oth	er (Specif)	v)								
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	ŀ	30. Name and address of person	who completed caus	se of death (Item	n 23a)										
		Russell Alexander MD). Assistant M	nedical Exan	niner 111	Penn St	reet, E	Baltimor	e, MD	21201					
Sta	ate	31. Date filed (Month, Day, Year)	4 2000 32. Re	egistrar's Signati	ure /		/							-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03:15AM Charles Harris Schuhart, November 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore If Under N/A Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, APR 26, . Age (In yrs. last birthday) Funeral Min. 1 XM 2 ☐ F 1931 214-26-3818 78 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar mans be notified at 1 ☐Yes 2 No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 107 S. Symington Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1952-54 1 □Yes 2X No Specify. ģ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Heath and Mental Hygien Important; If item 27 is marked other the any injury or other trainmain. Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Schuhart, Sr. Harris Edith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores C. Schuhart, wife 107 S. Symington Avenue Catonsville, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 12/03/09 Woodlawn, MD 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee George MacNabb 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** rocardia disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the detached 9 Unknown 9 Unknown signed by it 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 2 No 3 Probably 4 Unknown 1 ☐ Yes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred ie Hospitai or Attending P n 24 hours after death. ie Funeral Director: After t Certification: 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number P23488 November 28, 2009 o completed cause of death (Item 23a) (Type, Print) Caton Ave. Baltimore MD 21229 ristopker 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>11:</u>58a [™] MARY ANN THOMPSON 2009 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STELLA MARIS HOSPICE TIMONIUM 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. (Month, Day, Year, PR. 26 1 89 **Director** 462-38-3053 TEXAS APR. 1920 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified XX Yes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 1020 E. 33rd Street Apt 113 21218 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2**XX**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Specify: BLACK "natural" Completed 3 XWidowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE STAY HOME MOM 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ARZO BILLUPS ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Anna Thompson-Smith/Daughter 2213 Braddish Ave., Baltimore, Md., 21216 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST 12-08-09 OWINGS MILLS, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence off. Exami the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 X No 1 ☐ Yes ∠ ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 🗌 Yes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \mathbb{X} Other (Specify) **HOSPICE** 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft
To the Funeral Di
completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number K157624 11/30/2009

3

11:58

28, 2009

NOVEMBER

THOMPSON

State Registrar TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

CRNP

JENNIFER HAUF,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11-26-2009 Leslie Tabajdy 12:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Somerford Place Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 **X** M 2 □ F Months Hours Min. 03-09-1917 072-30-5321 92 **Director** Hungary Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Maryland ms 23a or 28a-f shortment should be most be notified at Director Howard Columbia 1 ☐ Yes 2 🌠 No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 7317 Eden Brook Drive, #206 21046 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö ð 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Specify. Specify. White "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Agriculture Engineer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of ၉ Daniel Tabajdy Lenke Skalla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or other trains. Ilona M. Tabajdy/wife 7317 Eden Brook Drive #206, Columbia, MD 21046 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 11/27/2009 Signature of Funeral Service Licenses Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia,MD 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: NA 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Year Month Day Pregnant at time of death 5 Other (specify) signed by the a g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed Yes To the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Assisted 1 Yes မှ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 1 Natural 5 Pending 1 Tes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D56531 November 27, 2009

State Registrar

DHMH 17 Rev 7/2009

#301 Columbia, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Snowden River Pkwy.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5151e18 Maryland 23e Barriffent 6898 and 2008 Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 13:32 PM NOVEMBER 23 2009 LEONARD /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F 224-38-4869 Virginia May 9, 1932 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10h County 10a State 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 21060 USA 107 Furnlea Drive items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 💢 No Specify black Specify: à 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk College (1-4 or 5+) Elementary/Secondary (0-12) other than furniture company and Mental Hygiene. delivery person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie Thompson Frances Robinson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trainonce. 9719 Branchleigh Road Randallstown, MD Maria Shears/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 4 Dopation 3 21 Other (Speed) Greenmount Crematory 12/09/2009 Baltimore ,MD State Anatomy Board 655 W. Green Cremarion Service Balilmore, MD 21201 21223 W. Baltimore Street 119-127 Stricker ST. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cau e (Final ANOXIC BRAIN 3 DAYS **Physician** disease or con resulting in death) /Medical Due to (or as a consequence of) 3 DAYS Examiner CARDIAC ARRES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 □ Probably 4 □ Unknown PNEUMONIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has d in by the funeral director, page 2 1 Tyes 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes death. 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide City or Town, State) within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 NOVEMBER 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M BOWMAN NATALIE 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 4 2009 32. Registrar's Signatur State green. Registrar

			For State Registrar	State of	Maryland / [rtment			and M	ental Hyg	giene Reg. No. 1	2009	38	739
			Decedent's Name (First, Middle	e, Last)							2. Date of Deal		Year	3. Time o	f Death
	Physici /Medi		William C.	Thoms							Novembe			2:00	PM ^M
	Exami		4a. Facility Name (If not institution	n, give street and numb	per)		4b. City,	Town, or	Location of	of Death		4c. C	County of Death		
-				g Factory				Be1					Harford		
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last bir	thday) Yrs.	If Under Months	Days Days	If Under Hours	Min.	8. Date of Birth (Month, Day July 20	Year C	9. Birthp Cour Wisc	lace (State try) ONS i n	or Foreign
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an	d be ental ked c	To Be	Walter Ernst 1	homs					F	ranci	is Marti	in			
Maryland	shou nd M mar	-	19a. Informant's Name/Relations	hip (Type. Print)	19b								Town, State, Zip	Code)	
Ž	nd 2 alth a 27 Is		Christopher Th	noms/son		7 S	edgew	rick	Drive	e E.	Berlin,	, PA	17316		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (5		20b. Place of cemeter	f Dispos ry, crem	sition (Nam natory or of	ne of ther plac	:e)	D	ate	20c. Loc	ation - City or To	wn, State	
Baltin	permit. F Departm Importar any injur		21. Signature of Funeral Service Ronald	1	rector	- 1			-			Bal	timore S	treet	
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			shock, heart failure. List Immediate Can e (Final	only one cause on eac	ch line.	1	1		100	, ,				Approxima Interval Be Onset and	tween Death
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Box	th cel	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		me of pregnancy th 2 Fetal death	3 🗆	Ectopic p	regnanc	V			2	3d. Date of delive Month	ery Day	Year
	dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death		Other (sp		<u> </u>				WOTH	Day	real
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sio	Attending or death. ector: After by the fune	cati	2 Accident investi 3 Suicide 6 Could	gation			М		Yes 2 🗍		201		(A)	of Parista No.	
Division of Vital Records,	or Att	Certification: To	4 Homicide determ	inod 28e. Place of	f Injury - At home, fa , etc. <i>(Specify)</i>	rm, stre	et, factory	, office		1	28f. Location (S City or Tow		Number or Run	ai Houte ivui	mper,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a, Certifier 1 Certifyin	ng Physician: To the b	est of my knowledge	e, death	occurred	at the ti	me, date a	nd place,	and due to the	cause(s)	and manner as	stated.	
	n 24 t n 24 t le Fut	Medical	(Check only 2 Medical one)	Examiner: On the bas and manne	sis of examination ar r stated.	nd/or inv	vestigation	, in my c	pinion, dea	ath occurr	ed at the time, o	date and	place, and due t	the cause	(S)
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			Kinus	4.14	elle in	7	D	00	362	-31		W	V 11	100	7
			30. Name and address of person	who completed cause	of death (Item 23a)	(Type, F								-	
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	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signature	and									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ma 1, DECEMBER 2009 11:45 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. eity, Town, or Location of Death 4c. County of Death Examiner GENESIS-HAMILTON BALTIMORE N/A7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 □ F Months Days Hours Min. Director 217-05-5291 90 MARCH 14,1919 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3711 FLEETWOOD AVE 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FELIX H. TERJUNG ပ ANNA KURRLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET TERJUNG-WIFE 3711 FLEETWOOD AVE BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 12/3/09 GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, 6415 BELAIR RD BALTIMORE, MD 21206 Rart1 Enter the c sea shock, or heart f ilure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Fin Physician disease or condition resulting in death) to ance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co sequence of) the death certificate be executed Exami 1 and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy ō in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 perform certificate 1☐ Yes 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 1 Yes 2 ER/Outpatient 1 Inpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 - Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

State Registrar

the

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Eleanor P. Vitocolonna 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan Hospital 8. Date of Birth (Month, Day, Yea May 3, 1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ Months Hours Alabama 168010106-184 1928 Director May 415-34-9679 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director Baltimore Carney MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21234 9304 Avondale Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐No Specify. If Yes, Give Completed 3€ Widowed 4 Divorced Year or Dates NITOCOLONNA 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montogomery Ward Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alma Campbell Ben James Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Jefferson Avenue-Cockeysville, MD 21030 ELEA NOR Raymond Vitocolonna-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Dec.3, 2009 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 Londrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Positive Physician/ Gram SEPSIS disease or condition resulting in death) COCEL Medical Due to (or as a consequence of): Examiner STAGE RENAL Sequentially list conditions, Due to (or as a consequence of): rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown VI TO COLONNA 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Coronary artem disease, Pulmonary 2 No 3 ☐ Probably 4 ☐ Unknown Completed Amal tribrillation 1 Tes iis certificate has been si director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an old Stroke embolism Hypertension, autopsy performed Hospital or Attending Physician: The 1 Yes 2 No EANOR Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Inpatient 2 ER/Outpatient 3 DOA 잍 this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vonthid9 Res 000 11/16/2009 Golde 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock) Reflect Blvd, Balh N 21239 32. Registrar Signat State

3. Time of Death

10d. Inside City Limits

Approximate

Day

Interval Between

Onset and Death

YGARS

1 Yes 2 X No

9.06 AM

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08:30 AM Physician/ 69 LUCINDA WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL ANNE HEUNDEL MEDICIAI ANNAPOLIS ENTER 8. Date of Birth (Month, Day, Year) Dec 4, 1917 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 244-58-1790 1 🗆 M 2 🗓 F 91 North Carolina Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Odenton 1 Tyes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 USA 1621 Winesapp Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛱 No Specify: If Yes, Give Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 1 and 2 should be fill of Health and Mental ည Elizah Hairston Henrietta Blackstock Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Irene Sizmore - Daughter 1621 Winesapp Drive Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Eden Garden Cemetery 12/8/09 Eden, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Perry Spencer Funeral Home 21. Signature of Funeral Service Licensee 27025 402 Short Ave. Madison, NC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONARY Physician/ POSSIBLE PUL disease or condition resulting in death) MINUTES Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear 4 Pregnant a Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 1 24 hours after death. Funeral Director; After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certi 29c. License number 12/2/0 066753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy M. Capstac 2001 Midica

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Saltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38743 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 12-01-2009 John W. Walls 2250 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09-03-1920 **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F 235-26-3502 89 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f shov 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at Director MD Harford Abingdon 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 West Baker 21009 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑|Yes 2 □ No If Yes, Give Year or Dates; 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Pages 1 and 2 should be filed within 72 hours aftenent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or i Completed by 1 ☐Yes 2X No 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Petty Officer US Navy 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Theodore L. Walls Dell Ferrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLifford Taylor (Bro.-In-Law) 1331 Saratoga Drive Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12-04-2009 Baltimore, MD permit. 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner arrinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): Jalls, John M 800434447 。 Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Day 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? , page autopsy perform 1 □ Yes 2 🗀 No Hospital or Attending Physician; funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 400 67817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar 31. Date filed (Month,

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0530M November 28 2009 Vatson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GNES HRSPITAL If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, f Under 1 Year Birthplace (State or Foreign Count) Age (in yrs. last birthday, **Funeral** Days Hours Min 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a, State if Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evander must be notified at 1 Yes 2 □ No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numb thenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 12 11. Marital Status Black White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Maryland 21215-0036 Blac à 3 ☐ Widowed 4 Divorced of Business/Industry Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Deaton Elementary/Secondary (0-12) College (1-4or 5+) √urse 18. Mother's Name (First, Middle, Mai Name (First, Middle, Last) 17. Fatheri and 2 should be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nam's Name/Relationship (Type. F Honapolis, MD 21403 onle 10hnson Baltimore, 20c. Location - City or Town, State Place of Disposition (Name of demetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. Baltimore, InD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12.5.09 of Funeral Service Lice 21. Signatur Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mudcardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence f) Examiner cerebe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-trans Due to (or as a consequence of) attending pl IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the detached 9 Unknown has been signed by e 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy , page certificate 2 🗆 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Impatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce tifi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day,

REED

4 2009

Year)

MD

Registrar's Signature

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BALTIMORE, MD 2 H29

aylor vvagner		State of Maryland 1- For State Registrar		ment of H ficate of D		d Menta		eg. No.	200	10 2071
Physicia		Decedent's Name (First, Middle, Last)					2. Date of Deat	:h	Year	3. Time of Death
Medical Exami	ner	Taylor Kathleen Wagner 4a. Facility Name (if not institution, give street and number)		145.7	City, Town, or	Laustina of F	November		9 unty of Death	0827 hrs
		Johns Hopkins Hospital			altimore	Location of L	Death	4c. Cot	inty or Death	
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last		Under 1 Year		4Hrs. 8. Date of Birl	th(MM/DD/Y	(YYY) 9. Birt	thplace (State or
Director		214-85-6184 1_M 2XF		Yrs.	Months Days	s Hours	June 1	, 200	9 Co	^{untry)} Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location						10d. Inside City Limits
) }	7	Maryland	Balt	imore						1 X Yes 2 No
Maryla	Director	10e. Street and Number			f. Zip Code		10	0g. Citizen o	of What Cour	ntry?
ith the 23a or notifie		3011 O'Donnell Street			21224			USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be natified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces 2	>	13. Was De	ecedent of His specify Cuban	spanic Origin? n, Mexican, Po	? (Specify Yes or No- uerto Rican, etc.)		Race - Ameri White, etc.	can Indian, Black,
after d al", or	by Fu	3 Widowed 4 Divorced If Yes 2 If Yes, Give Year or Dates:	X No	1 Ye	s 2X No	specify:		Spec	^{cify:} Whi	.te
hours. natur		15. Decedent's Education (Specify only highest grade con		Sa. Decedent's U	Jsual Occupat				of Business/I	
36 hin 72 e. than t	ompleted	Elementary/Secondary (0-12) College (1-4 or s	5+)	Infant			,	T		
5-00 led wit tygien other	Con	17. Father's Name (First, Middle, Last)		mirant		18.Mother's N	Name (First, Middle, M	Infan Maiden Surn		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Kevin Emory Eldreth					Kathleen			
MD 2 d 2 shoul lth and M n 27 is m	^L	19a. Informant's Name/Relationship (Type, Print) Kevin E. Eldreth / Father	7				r or Rural Route Num			
e, N and 2 Health item 2		20a. Method of Disposition	20b. Plac	ce of Disposition	(Name of cer	metery,	Date Dat		tion - City or	yland 21224 Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	I	matory or other p top Ser	•	orp. 1	2-3-09	Томя	son. M	aryland
Salti ermit. epartn mports ijury e		21. Signature of Funeral Service Licensee	r- 0	22. Name	and Address	of Facility M	icComas Fu	neral	Home,	P.A.
Physician	15	23a. Part I. Enter the disease, or complications that caused	the death. Do	11317	Cokes	bury R	oad, Abine	gdon,	Maryl	and 21009
/Medical	1 1	failure. List only one cause on each line.						sot, smoot, c	ii neart	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Sudden undeath	equence of):	ned dea	ch ib	inland	y (SUDI)			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a const	equence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated								
ansit de CC		events resulting in death) Last Due to (or as a conse	equence of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medical	X UNPENDED X AMENDED 23a	,27,28	a-f,per	mE, g8	99 1/2 /09 TT	9/10 TT			
3760, ficate be g physici	/Me	IF FEMALE: 23c. If yes, outcor	ne of pregnan	ncy					te of delivery	,
30x 6876 death certificate e attending phy for use as the	iciai		time of death	2 Fetal d	eath 3 [(Specify)	Ectopic pr	egnancy	Mon	.tn L	Day Year
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ires that t	<u>₹</u>	Part II. Other significant conditions contributing to death	1 but not resul	iting in the unde	nying cause g	jiven in Part i				the cause of death?
rds, require been si	eted	Y					24a. Was a			topsy findings available
eco he law ate has	ompleted						autop. perfor	med?	prior to death?	completion of cause of
of Vital Records, ng Physician: The law require. The tribuse is the tribuse or the tribuse in the specificate has been simeral director, page 2 should be	Be C	25. Was case referred to medical examiner?	-				neck only one)	2 110	1 🗸 16	2 10
F Vit	ို	1 ✓ Yes 2 No Hospital 1 Inpatie		VOutpatient 3				Residence		r:
nding th.	<u>ii</u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju (Month, Day, Y	ear)	8b. Time of Injury	L arris	ryatWork? ∕es 2 X No	28d. Describe h	now injury or	curred	
Division tal or Attendi rs after death. al Director: /	licat	2 Accident Investigation Fd 11/2 3 Suicide 6 X Could not be 28e. Place of In		d 7:30 a	3111		28f. Location (S	Street and N	umber or Ru	ral Route Number, City
Division of Vital I ospital or Attending Physician: bours after death. uneral Director: After this certifity filled in by the funeral director.	Certification:	4 Homicide determined (Specify)	ouse				Baltimo	tate)301 re,MI	l O'Do	nnell St
± 22 ₹ 5		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of example one)								
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier			29c. License					nth, Day,Year)
		Panelto Fronthall no	10		O.C.I	M.E.			ber 28, 20	
4	1	30. Name and address of person who completed cause of d						<u> </u>		
W		Pamela E. Southall, MD Assistant Medi 31. Date filed (Month, Day, Year) 32. Registrar		ner 111 P	enn Street	t, Baltimor	e, MD 21201			
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar	1 /	ale						
DHMH 17 Rev 1/20 OCME 2006	01		C	RIGINAL				OCME		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 200 amue Ward 4a. Facility Name (If not institution, give street and number) County of Death 4b. City. Town, or Location of Death mare, mo N/A 5. Social Security Number Med 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 12 M 2 □ F Months Days 215-28-4410 May 26, 1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location Y☐Yes 2 ☐ No **Baltimore** n/a Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 827 Arlington Avenue 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sparrow Point Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Hall Samuel Ward Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Arlington Avenue- Apt 314 Baltimore, Maryland 21217 Florence Ward 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/09/09 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Sign turn f Funeral Service Licen 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smediate Council (Figure 1). Immediate Cause (Final disease or condition resulting in death) Cancer Due to (or a a consequence of): str.dien Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducito (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💇 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 ☐ Yes 2 🗆 No 26. Place of Death (Check only one)

Physician /Medical Examiner certificate be executed

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certificate

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After

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filled in by

death.

within 24 hours after death To the Funeral Director;

To the Hospital

Box 68760,

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of Vital Records,

Division or Attending **Physician**

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

e filed within 72 hours after death with all Hygiene.

Mental and Menta

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic evone.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Examine burial-tran attending physician for use as the buria Physician/Medical signed by the a d be detached f <u>გ</u> page 2 should Completed funeral director, Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Natural

3 Suicide

2 Accident

(Check only one)

Hospital: 1 Inpatient 5 Pending

Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier arens mo

investigation

29c. License number Dod 7708 29d. Date signed (Month, Day, Year) 11/28/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2009 15 Poul Place 32. Registrar's Signature

		1 - For State Registrar	State of Maryland / Depa <i>Cei</i>	artment of Health and M rtificate of Death	ental Hygiene ِ Reg. No. 4	2009 38747
Physic /Med		1. Decedent's Name (First, Middle, Last) GLORIA YON	IKOSKI		2. Date of Death Month Day	Year 3. Time of Death
Exami		4a. Facility Name (If not institution, give street HARBOR HOS PI 7AL	. CENTER	4b. City, Town, or Location of Death BALTIMORE	4c. C	ounty of Death
Funera Director		5. Social Security Number 214-44-5533 Usual Residence of Decedent	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 5 (Manth Day, Year) 4 4	9. Birthplace (State or Foreign Country) Mary Land
Maryland -f show	tor	10a. State 10b. County MD Carrol	10c. City, Town or Lo	cation Westminster	•	10d. Inside City Limits 1 □ Yes 2 ☒ No
with the 3a or 28a	Il Director	10e. Street and Number 2540 Halter	Rd.	10f. Zip Code 21158		en of What Country?
5-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show dieal Evaninar must be notified at	by Funeral		Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥No	Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	4. Race - American Indian, Black, White, etc.
within ene.	Completed	15. Decedent's Educat (Specify only highest grade of	College (1 Apr 5) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) dministrative	ng	d of Business/Industry
faryland 2 2 should be filed and Mental Hygi Is marked other aumatic event, the	To Be C	17. Father's Name (First, Middle, Last) William Clyde		Marguer	(First, Middle, Maiden S ite Juanit	a Clark
es 1 ai of Hei fitem	ŀ	19a. Informant's Name/Relationship (Type. David F. Yonkosk 20a. Method of Disposition 1□ Burial 2 ☑ Cremation 3 □ Rem	i – husband 2540 2540 20b. Place of Disponentery, cremetery, cremetery, cremetery.	natory or other place) 12-	stminster,	
Baltimo permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee	PH 12 22	arroll Crem. Name and Address of Facility Fl St. Main St.	etcher Fur	neral Home
Physician	_	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)		000 NOV 10	or respiratory arrest,	Approximate Interval Between Onset and Death
icate be executed Examiner physician and the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): COA (ULO PIF ITY Due to (or as a consequence of): CEPSIS DUE Due to (or as a consequence of):	DUE TO HEPATO	TIC FAILU	I WEEK
68760, c	edical		RENAL FAIL	URE		1 WEEK
P.O. Box 60 nat the death certific d by the attending petached for use as	Physician/M	IF FEMALE: 23c 23c in the past 12 months? 1 □Yes 2♥ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)	2:	3d. Date of delivery Month Day Year
ds, P.O. I	ρ	Part II. Other significant conditions contrib	•	nderlying cause given in Part I. TRACHEOS7014		e contribute to the cause of death? (No 3 ☐ Probably 4 ☐ Unknown
Record The law requir	Completed		DISEASE STAGE		24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \ 2 \] \] No
on of Vital Reding Physician; The In. After this certificate his funeral director, page	To Be	TE TES ZIAINO	pital: 1 Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 6	□ Other (Specify)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day, Year) 28b. Time o Injury 28e. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 □Yes 2 □ No	28d. Describe how injury 28f. Location (Street and City or Town, State)	Number or Rural Route Number,
Divisic To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		ian: To the best of my knowledge, deat :: On the basis of examination and/or in and manner stated.			
To the within To the comp	Š	29b. Signature and title of certifier) M·D.	29c. License number RES -001-	NECE	signed (Month, Day, Year)
40		30. Name and address of person who comp HANEEN ATBAK 31. Data filed (Month Pay York)	oleted cause of death (item 23a) (Type, 3001 L. HAN OVE	R STREET , BALT	IMORE MA	RYLAND 21225
Si	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 24 WALTER ZAIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BAUTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CEMEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** (Month, Day, 213-22-4064 Months Days Hours Min. Maryland Director 83 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 3464 Yorkway 21222 USA or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2X Married Yes 2 No Yes, Give hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 marked other than uld be filed within I Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Machine Operator Tool & Dye Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Zais Hattie Farrell and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Helen Zais wife 3464 Yorkway, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Holly Hill Memorial Middle River, MD. 4 Donation 5 Other (Specify) 5, 2009 gnave e of Funer I Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. ont enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) DAY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Other (specify) Pregnant at time of death 5] Yes 2 □ No 9 Unknown 9 Unknown P.O. þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending n 24 hours after death.

e Funeral Director: Al 1 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) RES-000 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOVIL 4940 EASTONN AVENUE BALTIMORE ASHUL 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene \(\chi \) \(\O \)

			State of Maryland / Departmen	it of Health ar <i>e of Death</i>	nd Mental Hyg	giene 2009	38749
			Registrar 1. Decedent's Name (First, Middle, Last)	- Dealli	2. Date of Dea		3. Time of Death
	Physici /Medic		ANNA ZIEGLER		Month Novemb	Day Year	
*	Examin		4a. Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of I	Death	4c. County of Death	<u> </u>
				LANDAUS 7 1 Year If Under 24		BALTI	
	Funeral Director		212 20 70/// 1 M 2 N F Yrs. Months		Min. (Month, Day	y, Year) 9. Birti	nplace (State or Foreign untry)
	D		Usual Residence of Decedent		June 12	., 1920 Mar	yland
	arylan show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Ma	Director	MD Baltimore Baltimore	0-4-		10 (1)	1 ☐ Yes 24 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Individual Evan instruct be notified at once.	JO IC	106. Street and Number 6825 Campfield Road 2F	21207		10g. Citizen of What Cot USA	aritry :
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, specific yes, specific for the control of the control o	dent of Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer	
36	or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes		r derio riiodii, eto.		hite
21215-0036	enter	led k	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usu:	al Occupation		16b. Kind of Business/I	ndustry
215	hin 72 e. an "na	Completed		rk done durina most o	of working		,
21	ed wit lygien rer th	Con	11 0 homemak			own_home	
and	be fil ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Charles Edward Burk		s Name (First, Middle,	ŕ	
Maryland	should nd Me mark matic	၉			rie Jane Al	r, City or Town, State, 2	Tip Code)
Ma Ma	alth ar 27 is er trau			,	oad Baltimo		·
ore	es 1 a		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Nar cemetery, crematory or or or or or or or or or or or or or	ne of ther place)	Date	20c. Location - City or	Town, State
altimore,	t. Pag rtment rtant: njury o		4 In Donation 5 □ Other (Specify)	1			
Ba	permi Depa Impor any ir once.		Ronald S. Wade Director State	Anatomy B	gard 655 W	. Baltimore	Street
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shook, or heart failure. List only one cause on each line.	more, MD de of dying, such as ca	Z I Z U I ardiac or respiratory an	rest,	Approximate Interval Between
· v	Physician		Immediate au e (Final disease or con Ition				Onset and Death
R.F.	/Medical Examiner		resulting in death) Due to (or as a const uence of):				
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c			4	
Ö,	e exec ian an ırial-tr		resulting in death) Last Due to (or as a consequence of):				
58760,	death certificate be executed e attending physician and d for use as the burial-transit	edical	d				
× 6	eath certific attending p for use as	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			00 d Data of dall	
Box	death e atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (sp			23d. Date of deli Month	very Day Year
д О	t the o	hysi	9 ☐ Unknown	*			
ς Ś	The law requires that the diate has been signed by the sage 2 should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I.		bacco use contribute to	-
ord ord	requir	sted			1 🗆 Y	es 2 No 3 Pr	obably 4 Unknown
Hecords,	23 2	Completed			24a. Was a autop: perfor	sy prior to d	topsy findings available completion of cause of
			25. Was case referred to medical	00 Plans	1 □ Yes	2 No 1 ☐ Yes	2.12(No
> :	ding Physician: The h. h. After this certificate h. funeral director, page	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC	Others	of Death (Check only or sing Home 5 ☐ Resid	lence 6 ∐Other (Spec	oifv)
n ot	ng Pr	T:U0	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	?8c. Injury at Work?		ow injury occurred	
ois :	tendi Jeath. tor: A the fu	cati	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
DIVISION	l or Al after o Direc	Certification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
	to the hospital or Attending Physician: To the Funeral Director. After this certific completely filled in by the funeral director, it		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation	at the time, date and	place, and due to the	cause(s) and manner as	stated.
	the F	Medical	one) and manner stated.	c. License number		29d. Date signed (Month	
	≅ <u>≥ 5</u> 8	-					
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D0059	136	november 2	1, 2009
			PEBORAH WATSON FITZER TRUCK MO	NURTH WE ST	(tosp (TA	L 5401 0	LO COURT ROTO
	Stat Registra		31. Date filed (Month, Day, Year) 2009 33 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 9, Harriett G. Adler 2009 2:40 a November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Bethesda Montgomery 5550 Tuckerman Lane #538 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/16/1922 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🖾 F 87 093-14-1910 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 TstYes 2 □ No Maryland Montgomery North Bethesda 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 5550 Tuckerman Lane #538 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President and JOP Associates Founder of Advertising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bela "unavailable" 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5550 Tuckerman Lane #538, North Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

Max Grossman

Charles Adler, husband 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Arlington National 21. Sign yure of Fu rvice Licensee 6

Leukemia

22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852

11/17/2009 | Arlington, Virginia

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final disease or condition resulting in death)

Physician

Examiner

Funeral

Director

28a-f show

23a or 2

items

"natural", or

the Medical Examiner must be notified at

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

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Certification:

Medical

the Marylan

Maryland 21215-0036

Baltimore,

within 72 l

12 should be filed w h and Mental Hygie 7 is marked other tl

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic evone.

Physician

/Medical

Examiner

and burial-trai

physician

the

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has page 2 s certificate

this

After

death.

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

10

Hospital or Attending

director

the as attending properties as

law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division of Vital

/Medical

10a. State

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

MO1255

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 🏝 No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Year

Assisted

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

freue

24a. Was an 1 □Yes 2 □XNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo

27. Manner of Death

1X Natural

2 Accident 3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

MD D-27660

29d. Date signed (Month, Day, Year) November 9, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goswani, 11125 Rockville Pike, Suite 110, Rockville, MD Alpan'a 31. Date filed (Morty) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	Baltimore, Maryland 21215-0036	036
the Hospital or Attending Physician: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	urs after death with the Maryland
	Department of Health and Mental Hygiene.	
After this certificate has been signed by the attending physician and	Important; If item 27 is marked other than "natural", or items 23a or 28a-f show	al", or items 23a or 28a-f show
empletely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Examiner must be notified at

Funeral Director

	For State	State of M	laryland / [Departme Certific			Mental Hy	/giene	2009	3875	
	Registrar 1. Decedent's Name (First, Middentification)		Certificate of Death				Date of Death 3. Time of Death				
dical	Howard	McCord		nethy					7, 2009		
niner	4a. Facility Name (If not institution 14566 Blythwo	r)	4b. City, Town, or Location of Dea								
al	5. Social Security Number		ge (In yrs. last birt	11009/	der 1 Year	If Under 24 Hr	s. 8. Date of Bi	rth	9. Birth	hplace (State or Foreig	
	217-32-4278	1⊠M 2□F	74	Yrs. Monti	ns Days	Hours Mir	Aug. 1	4, rear)	935 New	untry) 7 Jersey	
	Usual Residence of Decedent 10a. State 10b. Count	1	10c City Town	or Location						10d. Inside City Limit	
jo.		gomery		c. City, Town or Location 10d. In Burtonsville							
Medical Certification: To Be Completed by Physician/Medical Examiner A a b b b b b b b b b b b b b b b b b b	10e. Street and Number		Dare		Zip Code	- 112		10g. Citi	tizen of What Cou	untry?	
a D	14566 Blythwoo	od Lane	20866					Un	ited Sta	ed States	
mer	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was De	cedent of H	lispanic Origin? (Specify Yes or Norto Rican, etc.)	0-	14. Race - Amer		
굣	1 □ Never Married 2 ☑ Ma	No		2 ⊠ No	rto rtioan, cto.,		Black, White, etc. Specify: White				
d be	3 Widowed 4 Divorce	Year or Dates		Decadent's !!	cual Occur	nation		16h Ki	ind of Business/I		
plet	(Specify only high	est grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most done during most done				160. KI	ind of business/f	ndustry	
E	Elementary/Secondary (0-12)	College (1-4or	5+)	Мас	chinis	st		ι	U.S. Nav	y	
9g	17. Father's Name (First, Middle	•				18. Mother's Na	ame (First, Middle	(First, Middle, Maiden Surname)			
int; If item 27 is marked ott	Marvin David Abernethy					Ju1	ia	McCo:	rd		
							Rural Route Numb				
	Malinda Abernet	ny/Spouse				od Lane;	Burtons				
tant; If item ; jury or other	1 ☑ Burial 2 ☐ Cremation		9 '	y, crematory`c	r other plac	1	Date		ocation - City or T	· —	
3	4 Donation 5 Other (Parkla			1 *	11/09			Maryland	
0	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike; Rockville, MD 20852										
4	23a. Part 1, By er thy divease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate										
	shock, hear ta ure. Lis Immediate use (Filal disease or condition									Interval Between Onset and Death	
	resulting in death)		s cell c		na of	the right	ht jugul	od1a;	gastric		
	Sequentially list conditions,	b									
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s à consequence o	i).							
хап	that initiated events resulting in death) Last	c	s a consequence o	ift.							
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edic		d									
edical Certification: To Be Completed by Physician/Medical Examiner Sedical Cartification: To Be Completed by Physician/Medical Examiner Part Part Part Part Part Part Part Part	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							23d. Date of delivery			
sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant	at time of death	5 Other		y —			Month	Day Year	
Phy	9 Unknown 9 Unknown										
signed by d be detact	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Paroxysmal atrial fibrillation, hyperlipidem										
eted						٠,	1 Yes 2 No 3 Probably 4 Unk			JUADIY 4 UNKNOW	
Jgr.	Diabetes					24a. Was an autopsy			24b. Were autopsy findings available prior to completion of cause of		
								performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			
	25. Was case referred to medical examiner? Hospital: Other:										
eral direc	1 ☐ Yes 2 ☒ No										
ation	1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident invest		ay, Year) In	ijury M		(? Yes 2 □ No			,		
ific	2 Accident Suicide 6 Could not be 4 Homicide determined determined building sto (Specific) 286. Location (Citical Toles)								Street and Number or Rural Route Number,		
Cert	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)										
Ž	29b. Signature and title of certifie	in In I	(11)	7 2	29c. Licens	e number		29d. Dat	te signed (Month	, Day, Year)	
	D32923 11/9/09										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	Dr. Melissa B. Friedland 2415 Musgrove Road #105; Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Figistrar's Signature A Company Com										
tate trar		2 2009 Jene	ara Signature	back	1						
		Juliu	- /-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician Lafayette Samuel Arnold November 17,2009 3:15 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Hagerstowh Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 217-16-2199 83 Director March 10,1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must han access to the contract han a state of the contract has a state of 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Washington Hagerstown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 750 Dual Highway 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give 1944–1946 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Be Completed by Specify: 3 ☐ Widowed 4 ☐ Xivorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Masonary Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie 2 Irene Lafayette Arnold King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlene K. Lloyd 140 West Franklin Street, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery: 11-19-09 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 R hall Brac 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. betructive Immediate Cause (Final disease or condition resulting in death) DISCASA **Physician** chvonic /Medical Due to (or as a consequence of): Examiner 1 me N Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): physician Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autoosy perform 1□ Yes 2☑No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Pleavithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Baltimore,

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier

NOV 18 2009

31. Date filed (Month, Day, Year)

29c. License number 00060396

29d. Date signed (Month, Day, Year)

217

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURSHED FARID

and manner stated.

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh G899 1/8/10 TT

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^Dຊື່2009 Nov. 13, Walter Forward Austin II 11:40 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester 10358 Carey Road Berlin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | DeC. | 93, 5. Social Security Number 5127 6. Security Number 5127 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Mary Tand 1938 219-36-5126 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes Ž□No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10358 Carey Road 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ဤYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married white 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pilot Air Born Express 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert T. Austin Nancy Rieman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby Austin - sen 112 Joyce Lane Stevensville, MD 21666 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 11/16/2009|Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service 108 William Street Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 li oblastoma multitorme disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 □ Yes 2 □ No Day Year 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? iting to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

Examiner law requires that the death certificate be executed the burial-tran and Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending phase as the signed by the a ٥ icate has been siç r, page 2 should b Completed certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p Be Certification: To

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinan must be notified at

Hygiene.

it and 2 should be filed wi Health and Mental Hygier tem 27 is marked other th

Pages 1

Department of Health Important: If item 27 any Injury or other trong.

Physician

Examiner

/Medical

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Part II. Other significant conditions	s contribu
25. Was case referred to medical	

25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ② No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurred						
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	hysician: To the best of my knowledge, death occurred at the time, date and plan							

29b. Signature	and	e of certifi	er
		1	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Signature and the of certifier	29c. License number
	1)00/06/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

Medical

DN 6+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 5:00 a M 2009 November John Williams Bigelow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 8. Date of Birth Aug. 5, Year) 937 5. Social Security Number .Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Washington, DC 577-50-3062 72 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b, County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12609 Stable House Court 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married XX Married 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1959-60 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Raymond Bigelow Henrietta Dewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia A. Bigelow/Wife 12609 Stable House Court, Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 k Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2009 16 Silver Spring, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician (ancer disease or condition resulting in death) MNG Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury signed by the attending physician and deedached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna
 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Physician: The law requires 1 Tyes 2/ No 3 Probably 4 Unknown Records, director, page 2 should peen 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? certificate has perform 1 Yes 2 No 26. Place of Death (Check only one) Vital Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this o completed filled in by the funeral 28b. Time of 27. Man f Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural 5 Pending Division 1 🗌 Yes 2 🗌 No М Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29c. License numbe 29b. Signature and title of cert ed cause of death (Item 23a) (Type, Print) #358 Roclin le MD 20850

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Mona Catherine Blume 2009 14:10 VOVEMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Memoria If Under 24 Hrs Date of Birth (Month, Day, Year) Social Security Number Davs 1 ☐ M 2 👿 F Months Hours 214-05-7361 12/22/1912 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10 N. Liberty Street, Apt 403 21502 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Clerk <u>Retail</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warner DeBolt Cole Mayme 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel L. Blume, Jr./ son 11908 Iris Avenue, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dopation 5 □ Other (Specify) Sunset Memorial Park 11/11/2009 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Sig a re f Funeral Service Ligense 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 mg Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Ye ar Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Director

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r than "natural", or items 23a or 28a-f shov the Medical Econiner must be recilled at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exercitive once.

Baltimore, Maryland 21215-0036

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death w

Examine physician and s the burial-tran Physician/Medical attending p signed by the a þ Completed Jas certificate Be ျှ this Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed After thi funeral within 24 hours after death

To the Funeral Director: A

completely filled in by the f

Division of Vital Records, P.O. Box 68760,

9 🗆 Unknown						
Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 ∐ Yes 2	use contribute to the cause of death?	
Depress	A ST			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ■ No	
25. Was case referred to medical			ath (Check only one)			
examiner?	Hospital: 1 npatient 2] ER/Outpatient 3 □	DOA Other: 4 Nursing I	Home 5 Residence	6 ☐Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred	
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factorify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	nysician: To the best of my kniner: On the basis of examin				s) and manner as stated. d place, and due to the cause(s)	

29c. License number

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29d. Date signed (Month, Day, Year)

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State Registrar

Medical

29b. Signature and title of certifig

EMMARINEL OST BEAMA 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item 8 State Registrar 11/24/09 WCHD/SH per FH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mildred Louise Burger Vovember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington

8. Date of Birth 6/19/19/20 Arthplace (State or Foreign Month, Pay, Year)

Country) Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 💥 🗆 F 88 Director 216-22-9695 Maryland Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hyglene. It filem 27 is marked other than "natural", or items 23a or 28a-f show or other traunatic event, the thousal Examiner must be notlined at Yes 2□No MD Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U,S,A. 412 George Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 🎾 ☐ Married white Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) taverns Elementary/Secondary (0-12) College (1-4or 5+) waitress 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Suffecool Pearl Mowen ဂ္ 19a. Informant's Name/Relationship (Type. Rrint) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 William A.Burger 412 George St. Hagerstown, MD 21740 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Paul Cemetery 20a. Method of Disposition 11-21permit. Pages 1
Department of H
Important: If Itel
any Injury or oth Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clear Spring, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Donald Edwin Thompson Funeral Home, Inc 23a. Part 1. Enter the disease, or of implication, that caused the death. Do not enter the mode of dying, such as cardiac or respir flory arrest,

Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Brike wile **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner chlunchin ソへ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive birth 2 Fetal death Month Year in the past 12 months? 1 □Yes 2 □No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate 2 1N 1 ☐Yes 2 ☐ No 1 ☐Yes the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 Ho Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D (8019 Nov 18,2009 an D Test

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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HAGERSTOWN,

MD 21740

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State Registrar 31. Date filed (Month, Day, Year)

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John M. Brooks, MD , 110 Hospital Road, Suite 111, Prince Frederick, MD 20678

32. Registraris Signature

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Ammend #5 SS# CCHD/KDW 11/24/09 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:25pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3745 Birdsville Road Davidsonville Social Security Number 215–34–8440 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 05-27-1923 Mary Land Director 86 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 5.8 or 28a-f sho amportant: If item 27 is marked of other than "natural" or item Maryland or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3745 Birdsville Road 21035 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 underground lineman electric company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clarissa Marie Meade Paul Bassford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Davis Bassford, spouse 3745 Birdsville Rd., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Davidsonville Church 11-18-2009 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rausch Funeral Home, P.A. Signature of Funeral Service Licenses 22. Name and Address of Facility 8325 Mt. Owings, MD 20736 Harmony Lane, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a co Examiner 76 mes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Other (specify) Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 1 🗌 Yes 2 000 ျ 4 ☐ Nursing Home 5 Mesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: 1 Anatural injury work? 5 Pending death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide determined City or Town, State) Medical 29a. Certifier pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signa 29d. Date signed (Month, Day, Year, 85 JRW 15 me and address of person completed cause of death (Item 23a) (Type, Pril MD Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 38759 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Grace Patricia Burrs 1:30 AM 15, 2009 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 950 Lanvale Street Washington Hagerstown 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Months Days Hours 212-30-0599 74 September 23,1935 Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 950 Lanvale Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of Elementary/Secondary (0-12) College (1-4or 5+) Assistant Editor District of Columbia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aquila Gilmore Hazel Lancaster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Burrs, Sr. / Husband 950 Lanvale Street, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 11/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA KAY ROGERS Hyattsville, MD 20781 23a. Part . Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS OF THE LIVER YEAR Sequentially list conditions, if any, reading to numericalle cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEPATIC ENCEPHALD PATH 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: PANCYTOBENIA 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Examiner Examiner The law requires that the death certificate be executed P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical Division of Vital Records, been si has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be ၉ Certification:

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Exardrer must be notified at

Pages 1 and 2 should be filed within 72 hours after death vanned of Heath and Mehal Hygiene.
ant: If item 27 is marked other than "natural", or items 233 and or other traumatic event, its fredical Examination or other traumatic event, its fredical Examination or other traumatic event, its fredical Examination.

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Director

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25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D53634

29d. Date signed (Month, Day, Year) NOV 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 MEDICAL CAMPUS RD MATT BECKWITH HAGERS TOWN MD 2174 HAGERSTOWN

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A^{M} 11/14/2009 FREDERICK BRADFIELD 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 2003 Wintergreen Ave. District Heights 5. Social Security Number If Under 1 Year | If Under 2 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 🗆 F Months Days Hours Director 403-34-9854 2/14/1930 Louisville, KY Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be notified at 10a. State 10c. City, Town or Location Director 1X Yes 2 □ No Maryland Prince George's District Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2003 Wintergreen Ave. 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TYPS 2 If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: Black Ş 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, If a Medical Once. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Civil Engineering USAF</u> Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eddie Bradfield Vivian Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estella Bradfield / Wife 2003 Wintergreen Ave. District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/20/2009 | Cheltenham, Maryland Maryland Veterans 21. Signature of Funeral Service I 22. Name and Address of Facilit Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending phase as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: To the Hospital or Attending PhysIclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifiei 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11/18/2009 D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz 7525 Greenway Center Drive Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 2009 Registrar

DHMH 17 Rev 1/2001

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	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
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23											

12:25 P M

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death Vijay Karumbunathan,

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Physician Jacqueline Blueme1 9:05PM November 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manokin Somerset ncess Anne Year I If Under 24 Hrs. I s Monor 8. Date of Birth (Month, Day, Year) 09-23-1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Min. 1 □ M 2 💢 F Months Hours 212-48-9787 Switzerland 83 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience is a confined at 1XYes 2 □ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6265 Westbury Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۵ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Florist Floral none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andre Meystre Julia Cecile Clot ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6265 Westbury Drive, Salisbury, MD 21801 Catherine Betz/daughter other t Baltimore, If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department Important: If any injury o 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 11/05/2009 Salisbury, Maryland 21. Signature of Funeral Service Licensee Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 14 car /Medical Due to (or as a consequence of): Examiner 3 years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 1 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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Vovember 3, 2009

Division of Vital Records, P.O. Hospital or Attending To the Hospital Committee Within 24 hours after death.

To the Funeral Director: After the Funeral filled in by the fur

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier who was

DR. USITA NARSAN 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1415 S - DIVISION ST, 32. Registrar's Signature

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0051359

29d. Date signed (Month, Day, Year)

4-2009

SALISBURYIMO 21804

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36	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be profilled at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Yes 21	s?		Was Decedent of If Yes, specify Cul 1 □ Yes 2 🖾 No		n? (Specify Yes or N Puerto Rican, etc.)		ace - Ameri lack, White,	ican Indian, , etc. lack
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State Registrar

31. Date filed (Month, Day, Year) NOV 17 2009

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 38765 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>2009</u> Leonard Cross Lunn 12:45 pm Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1724 Priscilla Drive Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 🗷 M 2 🗆 F Months Hours 0276777977 Director west virginia 236-62-0384 92 Usual Residence of Decedent 28a-f shov 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits Maryland Montgomery 1 Yes 2 X No Silver Spring 5 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 23a 1724 Priscilla Drive 20904 U.S.A. items 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 5 Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1935 and Mental Hygiene. is marked other than "natural", If Yes Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify 1957 Year or Dates Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Officer U.S. Militar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfred Jethro Cross Sarah Elizabeth Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is Joselyn Makowski - Daughter 2329 Blue Valley Dr.. Silver Spring. MD 20904 Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. 11/30/2009Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician I be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24-burs after death.

To the Funeral Director: After this certificate has to the Funeral Director. After this page 2 s autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🛮 only one) Certifying Nurse Practioner. To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and add

31. Date filed (Mon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ANIE **Physician** ONWAY /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4q. County of Death Examiner DRIGHTFIELD PREE MARLECRO GEORGE KINCE If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 577-74-1361 1 ☐ M 2 🗡 F Months Hours Days 55 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once. UPPER MARLBORD 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? DRIGHT, LIEUS 20712 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) SENICR SYST. 17. Father's Name (First, Middle, Last)/ MITCHELL EDWARD ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) TLENWOOD 21. Signatur of Funeral Service License 2 Hacker SHUR ST NW Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BRONCHUS AND CHNG Immediate Cause (Final disease or condition resulting in death) TALIGNANT NECKLASM: **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-transit requires that the death certificate be executed Exami and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 st autopsy performe 2 No 1 □ Yes 2 X No 1 ☐ Yes Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Inpatient After this 27. Manner of Death

1 X Natural

2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred To the Hospital or Attending 5 ☐ Pending investigation r death. ours after death.
neral Director: A 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It w Marical Examinet must be notified at

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed by

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Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Physician/Medical signed by the attending | IF FEMALE: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been si should t Plabetes Huperdension this certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

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completely filled filled 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature a d title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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November 12, 2009

Johnson Dr. Frederick, MD 21702

Charles Wayne C		enger State	tate of Maryla	nd / De		ent of		and	Menta	al Hygi			200	1 a	3876
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Funeral	4	5. Social Security Number	6. Sex	7. Age (In yr	rs. last bit	rthday)	If Under		If Under	24Hrs. 8	3. Date of Bi	rth(MM/DD/	YYYY) g. Bi Fore	irthplac	e (State or
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Division of Vital Records, P.O. Boy ral or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the att led in by the funeral director, page 2 should be detached for	n: T	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury hth, Day Year) 1, 2009		3b. Time of	Injury 2	_	ıry at Wor	. Ir	28d. Descril Driver mo	be how injur	y occurred le crash		
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	one) 2 Medical E	xaminer:On the bas and manne	is of examina	ation and/	or investig	ation, in my	opinio	n, death o	ccurred at	t the time, d	ate and plac	e, and due	to the ca	
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6H-3	W	30. Name and address of personal Zabiullah Ali, M.D.	son who completed ca Assistant Med			111 Pe	nn Stree	et, Bal	timore,	MD 212	201				
	tate	31. Date filed (Months Day)		R gistrar's S		1 1	ak	/			-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year NOV. 16, **Physician** 4:10 A HELEN M. W. CLIFFORD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY 12801 Old Columbia Pike, #221 Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** . 191<u>2</u> Hours Months Days 97 Maryland 579-18-6784 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modion Examination on the continued of 10b. County 1 ☐ Yes 27 No Silver Spring Director MD Montgomery the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or: 20904 U.S.A. 12801 Old Columbia Pike, #221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>ک</u> Specify: Black 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Supervisor llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Edward Adams Mary Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau once. 2422 Branch Avenue, SE, Washington, DC 20020 Linda M. Faison (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from Stat Lincoln Mem Cem 11/21/09 Suitland, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licent 246 N. Washington St, Rockville, MD 20850 , or complications that caused the death ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Acute Preferated Intestine /Medical Due to (or as a consequence of) Examiner Colon Cancer Sequentially list conditions, Examiner Due to for as a consecutions of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 □Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown <u> Chronic Kidney Disease - Stage VI</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **X**0o 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

State

Registrar

106 Irving St, NW, Washington, DC

20020

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Cosette Jamieson, M.D.

NOV 18

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** $7:29 A.^{M}$ PAUL WILLIAM CHANEY 05 2009 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ALLEGANY CUMBERLAND WMHS MEMORIAL CAMPUS If Under 1 Year] If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/11/1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 □ F WEST VIRGINIA 236-58-1087 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show d other than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 😿 No Director RIDGELEY MINERAL WV 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 26753 25 MAPLE STREET by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1961 1 ∐Yes 27⁄2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PITTSBURGH PLATE and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) AND GLASS 12 LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I LUCY MAY GARLAND RUSSELL PARKER CHANEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) rmit. Pages 1 and 2 s partment of Health an portant: If item 27 is 1 y injury or other traur ROUTE 2, BOX 599, RIDGELEY, WV JANET KESSEL / EXECUTRIX 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or 4 ☐ Donation 5 【XOther (Specify)/ FNICMEMENT RESTLAWN MEML.GARDENS 11/09/2009 LAVALE, MD 22. Name and Address of Facility of Funeral Service UPCHURCH FUNERAL HOME, IN P.O. BOX 1260, FORT ASHBY 26719 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cordiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ule hour disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trans resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical use as the F FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) detached 1 Yes 2 No 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy perform 2 No 2 1 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗆 🎞 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital

of Vital Records.

NOS

State Registrar

Medical

29a, Certifier

30. Name and address of perse

and manner stated.

who completed cause of death (Item 23a) (Type, Print) 435

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vovembe 9:30 M Campbell, Van Liew Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 **X** M 2 □ F Months Days Hours Month, Day, Director 217-32-5504 92 1̈́917 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Washington 1 X Yes 2 No Hagerstown 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1018 Woodland Way 21742 U.S.A hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Seconday (0-12) Medical Doctor Medica1 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Dr. W. D. Campbell Marie Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda A. Campbell/Wife 1018 Woodland Way, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 11/21/2009 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complice ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only on Immediate Cause (Final staphlococcus backenica Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner malnutition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): エナフ Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Dav Yea signed by the a be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? ☐ Yes 2 🔼 No 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 2 No ပ 1 Yes 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

Dr. Andaleeb All

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

1368 MILL STREET, Hagerstown, MD, 21740

D66116

29d. Date signed (Month, Day, Year)

11/18/109

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 Evelyn Layton Allen Coyle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Comic 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Sex **Funeral** Months Days Hours 1 □ M 2 X F 79 04/24/1930 Director 220-26-3752 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City. Town or Location ed other than "nåtural", or items 23a or 28a-f show event, Ina Medical Examiner must be notified at 1 ☐ Yes Ž☐ No Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14 Juneway Lane **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 2/215-0036 1 ∐Yes 21k No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Office Manager Chamber of Commerce 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 Is marked of any Injury or other traumatic even ones. ဥ Leo B.Culhane Carrie M. Bartell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9953 Pitts RD Showell, MD 21862 <u> Ginger Allen Hadder (daughter)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 SrBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 11/20/2009 | Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that gaused the shock, or heart failure. List only one cause or each line Approximate Interval Between Onset and Death ised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** DIOMYOPATHY TAGR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) stor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Arther (Specify) HOSPICA Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DDA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital or within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DA 10 6 Huysus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Maureen Crawford Nance 2009 4:00 A M November 15. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 110 Goldstein Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Scotland 8. Date of Birth (Month, Day, Year) Mar 31, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1 ☐ M 2 🔀 F 79 Yrs. 1930 Director 218-98-1311 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Prince Frederick MD Calvert Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 20678 items 23a 110 Goldstein Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married White 0 1 □Yes 2 X No Specify Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any liviny or other traumatic event once. Be Galbraith Agnes Jardine Marshall ပ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Prince Frederick, MD 20678 110 Goldstein Road Campbell Crawford (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 17 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Clinton, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Owings, MD 20736 8125 Southern Maryland Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** una Canci 4001 /Medical Due to (on as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been signated p. ', page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury ours after death.
neral Director: A
y filled in by the ft. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 Homicide within 24 hours a To the Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road Ste 310, Prince Frederick, MD 20678 MD Gwyneth A. Blattau, 31. Date filed (Month, Day, Year) 32. Registra Signature State 7 2009 Registrar leneur

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

			ForState	State of Ma	aryland /			lealth and N	/lental Hyg	giene	
			Registrar			Cer	rtificate of	Death		Reg. No. 2	09 387/4
	Physici /Medic		DAVID MAURICE MAURICE 1. Decedent's Name (First, Middle, La DAVID MAURICE M						2. Date of Dea Month Novembe		3. Time of Death 12:45 at
and the	Examir		4a. Facility Name (If not institution, give				•	r Location of Death		4c. County o	
			8809 Ivory Gull 5. Social Security Number 6. 8		e (In yrs. last b	inth day)	Gaithe	rsburg	9 Data of Birth	Montg	
	Funeral Director		225-56-2280	1 ☑ M 2 ☐ F	68	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day June 30	, Year) , 1941	9. Birthplace (State or Foreign Country) Virginia
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation				10d. Inside City Limits
	Mary f sho	ģ	Maryland Montgo	merv	Gar	ithe	rsburg				1 ☐ Yes 2 🔀 No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country?
	th wit		8809 Ivory Gull	Court			208	79		United	States
36	d within 72 hours after death with the Maryland glene. In than "natural", or items 23a or 28a-f show the Marical Evaring roughed and the Marical Evaring roughed.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) If Yes, Give			Was Decedent of H If Yes, specify Cub 1 □Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, s, White, etc.
9	tural		15. Decedent's E	Year or Dates:	16	a. Dece	dent's Usual Occup	pation		16b. Kind of Bus	White siness/Industry
215	e. In "na In "na	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5		(Give	kind of work done DO NOT use retire	durina most of work	ring		,
212	d within giene. er than "	Completed	Elementary/Secondary (0°12)	5+		Rese	arch Sci	entist		Federa	1 Government
pu	be filed tal Hygi d other event, II	Be (17. Father's Name (First, Middle, Last	,				18. Mother's Nam			9)
yla	2 should be filed and and Mental Hygin and Mental Hygin is marked other raumatic event, II.	၉		ck Maurice						Mabel	Powell
Mai	d 2 sh th and 7 is n traun	3	19a. Informant's Name/Relationship		1			and Number or Ru			
ē,	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		Virginia R. Davis 20a. Method of Disposition	s/spouse			Sition (Name of natory or other place		Date		MD . 20879 Dity or Town, State
m O	Pages lent of nt: If I		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.		1			atory 11/	16/09	Alexandi	ria, Virginia
Baltimore, Maryland 21215-0036	permit. Pages 'Department of Important: If Ite any injury or of once.		21 Signature of Funeral Service Lice	·	00			ss of Facility De			
<u> </u>	8 9 E 8		Muchan	Chlu		10	East Dee	er Park D	r., Gait	hersbur	g, MD. 20877
De deren	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on each line a. Myocard Due to (or as a	_{ial In:}	farc		ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
100	Examiner		Sequentially list conditions,	b. Coronar			isease				
	ed sit	iner	cause. Enter Underlying Cause (Disease or injury	Sua to (unas a		e of):					
	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c. H erte Due to (or as a		e of):					_
68760,	ficate be executed physician and s the burial-transit	edical		d							4
O. Box	the death certi y the attending ched for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 Live birth	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					23d. Date Mon	e of delivery hth Day Year
of Vital Records, P.	uires that in signed by Id be deta	þ	Part II. Other significant conditions of Type II Diabetes		ut not resulting	in the ur	nderlying cause giv	en in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
COI	law requires as been sign 2 should be	Completed							24a. Was a		Vere autopsy findings available
<u>~</u>	0 - 0	mo			-				autop perfor 1 🗆 Yes	rmed? de	rior to completion of cause of eath? □Yes 2□No
/ita	slcian: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea			
of V			1 ☐ Yes 2 🔀 No		ent 2 ER/C	<u> </u>		4 LI Nursing H		lence 6 Othe	
n C	After After funera	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day		. Time of Injury	Wor	ryat k? Yes 2 □ No	28d. Describe h	ow injury occurre	ed
Division	death death ctor: y the	ficat	2 Accident investigatio 3 Suicide 6 Could not b	e 290 Place of Init	ury - At home.	farm, str	eet, factory, office	Yes ZLINO	28f. Location (S	Street and Numbe	er or Rural Route Number,
ο	al or A s after al Dire	Certification: To	4 ☐ Homicide determined	building, etc			, ,,		City or Tou		
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	To th withir To th comp	Me	29b. Signature and Moof certifier				29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	1 D			- No			D	57305		November	16, 2009
			30. Name and address of person who	•						36 3	20070
	Sta	te	Jeremy J. Janssen 31. Date filed (Month, Day, Year)	, M.D., 7 (Granite	Pla	ace, # 14	, Gaither	sburg,	Mary⊥and	1 208/8
	Sta Registr			109 Ocheun	ar's Signature	400	weed.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 2. Date of Death Decedent's Name (First, Middle, Last) Physician November 6200 itton nda /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 - M 2 X F 03/27/1958 washington. 215-72-5656 51 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar 23a or 28a-f show must be notified at 1 X Yes 2 No Directo Anne Arundel Orchard Beach Maryland | 10g. Citizen of What Country? 10e. Street and Number U.S.A 1916 East End Drive 21226 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 11. Marital Status 1 Never Married 2 X Married o 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify δ 3 Widowed 4 Divorced Caucasian 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) d other than went, the Me ith and Mental Hygiene. Elementary/Secondary (0-12) Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabry Spann Burkett Marilou Estelle Jeffries ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 14 Woodmore Drive, Silver Spring, Maryland 20901 Marilou E. Burkett - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 χ Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/2009 Silver Spring. MD Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas shock, or heart failure. LANDIBA ALBKANS FUNGEMIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** BACTEREMA SEUDOMONIAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MULTI ORGAN or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 \square Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: After 1 X Natural 2 ☐ Accident 5 Pending Injury s after dean.

All Director, After

No the for 1 Yes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only one) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) Gignature and title of certifier 2009 0069614

State

DHMH 17 Rev 1/2001

Registrar

600 North Wolfe St, Baltimore, MD, 21287

Name and address of person who completed sause of death (Item 23a) (Type, Print)

40

MY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 21 per FH G898 12/23/09 dk
State of Maryland Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9, Month Physician Paul James Dorsie 2009 1:30 a November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
July 13, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year, 1 → M 2 □ F Months Days Hours 1918 Pennsylvania 91 160-12-2199 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show other than "natural", or items 23a or 28a-f showent, the Medical Experiment must be notified at 1 ☐ Yes 2 K No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20902 10500 Glenhaven Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 XYes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo If Yes, Give Year or Dates: Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1942-57 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) First Lieutenant Army Air Corps 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) Be Anna Stupka Peter Dorsie ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10500 Glenhaven Drive, Silver Spring, MD 20902 Masae Dorsie/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Arlington National 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 21, Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2009 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Infected Sacral Decubitus Ulcer Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit law requires that the death certificate be executed Failure To Thrive Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Advanced Lung Cancer Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page 2 🔼 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗷 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No After this of funeral dire Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 ☐ Pending 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier D0067279

Registrar
DHMH 17 Rev 1/2001

State

Suganthi

1500 Forest Glen Rd. Silver Spring. MD

person who completed cause of that (Item 23a) (Type, Print)

Veerappan,
Begistrar's Signature,

Alagasarmi

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Month Year **Physician** :48 PM PAUL JOSEPH DETRICK, SR. 11 09 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1200 BROWN AVENUE CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/04/1933 Birthplace (State or Foreign Country) **Funeral** Hours 1**∑**M 2□F Months Days 76 WEST VIRGINIA Director 234-44-7044 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director MD ALLEGANY CUMBERLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 1200 BROWN AVENUE 21502 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: à 3 Widowed 4 Divorced WHITE Completed n and Mental Hygiene. Is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) OPERATING ENGINEERS Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR LOCAL #37 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LORENZO WILLIAM DETRICK ENDA MAY METZ ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trau once. LINDA DETRICK / WIFE 1200 BROWN AVENUE, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY 11/11/2009 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 21. Signature of Funeral Service Lice 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one caus in the characteristic of the control Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 40011 disease or condition resulting in death) /Medical up to (or a a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐Yes 2 HNo director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death. e Funeral Director: Af 1 Tyes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2

State Registrar

nos

29b. Signature and title of certified

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the

death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009

38778 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** nth 11/06/2009 Santos Echeverria 02:02 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery <u>Shady Grove Hospital Center</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ₹ M 2 □ F Yrs. 53 Director 05/06/1956 Honduras None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event, in a Modifical Extra chartment but within at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Gaithersburg Md Montgomery 10g. Citizen of What Country? 10e. Street and Number 20335 Gentle Way 20886 Honduras Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Specify: Honduras Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No þ Specify: Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Labor 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernabe Cordova Torres Vicenta Abrego Echeverria 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Marina Cordova/Niece 20335 Gentle Way, Gaithersburg, Md 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/18/09 General Cemetery Honduras nature of Funeral Sen 22. Name and Address of Facility John T. Rhines Funeral Home Þ 3005 12th St. NE Washington D.C. 20017 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastro intestinal Bleed 1 /Medical Due to (or as a consequence of) Examiner Advanced Hepatic Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine the Hospital or Attending Physician. The law requires that the death certificate be executed attending physician and for use as the burial-transit Primary Ocular Melanoma Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐Yes 2 ☐No After this certific funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD D0067386 11/06/09 8:30 a.m. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia John, MD 9901 Medical Center Drive, Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

NOV 12

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2009 9:40 November Gertrude Krueger Evans-Walker 14, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Vantage Health If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Hours Months Days 1 □ M 2 🔀 F 01/21/1906 North Dakota 411-32-2251 103 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the "Moleal Exercitor must be notified at MD Columbia 1
▼Yes 2□No Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 United States 5400 Vantage Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Specify: White ģ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnetic pages." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John F. Krueger Eva Merle Barnum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5612 Lamar Rd. Bethesda, MD 20816 John P. Evans / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington Nat. Cemet. 12/02/2009 Arlington, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. Juneral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertension **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal Insufficiency Sequentially list conditions, it immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Dementia and burial-tran Due to (or as a consequence of) P.O. Box 68760, Hypothyroidism Physician/Medical the attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Depression Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) incurrently of. 31. Date filed (Month, Day, Year) State NOV 18 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NCV. 8, **Physician** 2009 2010 P ANTWANTTE FOSTER BONNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Y 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year} 1953 Days Hours Months Min Maryland 1 □ M 2 🔀 F 56 578-74-9609 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination must be notified at Rockville 1 ☐ Yes 2 No Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 20851 13005 Twinbrook Parkway, #T-6 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XXX0 Specify Specify: Black þ 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Jefferson Russell Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 712 Tuckerman St, NW; Washington, DC Monte Foster (Son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of pempetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Mincoln Cemetery 11/14/09 Bladensburg, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility SNOVDEN FUNERAL HOME, P.A. o Funeral Service licenses 246 N. Washington-St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 XNo the detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cirrhosis page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/9/09 D064502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850

Registrar DHMH 17 Rev 1/2001

State

Brian Carpenter, M.D.

2009

32. Pegistrar's Signature

State Registrar



eted cause of death (Item 23a) (Type, Print)

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	Physicia		1. Decedent's Name (First, Middle, Last) MARGARET V		ANKLIN		Date of Death Month	Day Year	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	1 11	4b. City, Town, or Locat	tion of Death	NOVEMBE	R 10.2009 4c. County of Death	6:45A M	
			FREDERICK MEMORIAL HOSP 5. Social Security Number 6. Sex 7. Agr		FREDERICK	04 H I		FREDERI		
	Funeral Director		048-18-3776 1 □ M 2 🖫 F	e (In yrs. last birthday) 94 Yrs.	Months Days Hou	urs Min. S	8. Date of Birth ept 29	(ear) 1915 Ma	nplace (State or Foreign ntry) ry1and	
	and show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
	Maryla 28a-f	irect	Maryland Frederick	Thurmon	t			1 ☐ Yes 2 🔀		
	e filed within 72 hours after death with the Maryland Ital Hygiene. 9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Funeral Director	10e. Street and Number 8518 Orndorff Road		10f. Zip Code 21788		10	g. Citizen of What Cou	untry?	
	r items		11. Marital Status 12. Was Decedent 8 Armed Forces?		. Was Decedent of Hispanio If Yes, specify Cuban, Mex	c Origin? (Speci xican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White		
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Maryland 21	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) John Nathaniel Franklin				First, Middle, Ma			
az	e 1 and 2 should be file of Health and Mental F If item 27 is marked o' r other traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Nu		Elizabe		Code)	
	and 2 s Health em 27 ther tra	3	Lyla M. Franklin / Sister-i 20a Method of Disposition		855 St. Antho		-			
mor	Page 1 nent of ant; If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ge Cemetery	11/14		oc. Location - City or Tourmont, Ma		
Baltimore,	permit. Page Department of Important; If any injury or once.		21. Si prature o Euneral Service Livensee	/ S/4	22. Name and Address of F ROBERT E DA	acility ILEY &	SON FUNI	ERAL HOMES	P.A.	
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not en	OLO HAST MALI	N STREE	I THUR	4ONI MARYI	AND 21788 Approximate	
- 4	hysician/	19	shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition	ASC					Interval Between Onset and Death	
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	sate be executed physician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a	a consequence of):						
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	ertifica Iding p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy				22d Date of deli	ion.	
. Box bg	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Physician/M		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli	Day Year	
IS, P.O.	uires that t n signed b uld be detz	by	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause given in F	Part I.		acco use contribute to	the cause of death?	
Vital Records,	he law req tte has bec age 2 shor	Completed				_	24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of	
Ta I	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?		T	Death (Check o		La NO	ZUNO	
0	g Physics of this ceral direction	e: To	1 ☐ Inpatie 27. Manner of Death 28a. Date of injure	ent 2 ER/Outpatie	of 28c. Injury at		e 5 Residen	ce 6 Other (Specif	y)	
0	tending Jeath. tor: Aft. the fun	Certificate:	1 Natural 5 Pending (Month, Day 2 Accident Investigation 3 Suicide 6 Could not be		work? M 1 ☐ Yes	2 🗆 No				
DIVISION	al or At s after of l Direct d in by		4 Homicide determined 28e. Place of Injubuilding, etc	ry - At home, farm, st . (Specify)	reet, factory, office	28	f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,	
	ne Hospitt n 24 hour ne Funera pleted fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of example only one) Certifying Physician: To the best of the basis of example of the basis of example only one)	camination and/or inve	stigation, in my opinion, dea	ath occurred at th	e time, date and	place, and due to the ca	ause(s) and manner stated.	
	vithi Com		29b. Signature and title of certifier	~	29c. License numb	5 4 9	29	d. Date signed (Month,		
	Arl		30. Name and address of person who completed cause of de	eath (Item 23a) (Type.	Print)				,	
١				Thomas Jo	hnson Drive,	Freder	ick, MD	21701		
	Stat Registra		MOU 4 O coho . A	news A.	parker					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Charlotte Ellen Faith 11-21-2009 5:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS Health Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10-17-1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☑ F 218-76-3990 82 Mercersburg, PA Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show la or 28a-f sho t be notified a Clear Spring 1 ☐ Yes 🏖 ☐ No MD Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14712 Mercersburg Rd 21722 U.S.A. must b Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status i "natural", or itemi ledical Examiner r Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white ò 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical lith and Mental Hygiene.

27 Is marked other than ""
r traumatic event, the Med residence entary/Secondary (0-12) College (1-4or 5+) Homemaker 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Timmons Mary Robison 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Nellie Atherton daughter 11119 Hunter Rd. Mercersburg, PA 17236 Department of Health Important: If item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 25 Nov. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Clear Spring, Little Rose Hill 2009 21. Signature of Funeral Service License 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

| MD 2172 | Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** onarv Medical Due to (or as a consequence of): £xaminer amplications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 1 ☐ Yes 2 ☐ No 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CRNP 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14014M41 Stephanie 31. Date filed (Month, Day, Year) NOV 24 State Registrar

DHMH 17 Rev 1/2001

ndrew Farrell		State of Maryland / Departmen 1- For State Certificate			Menta	al Hygie		. No. 200	9 3878
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)		-		2. Da	Reg te of Death		3. Time of Death
Medical Examir		Andrew Michael Farrell				No	_{vember}	Day Year 26, 2009	0030 hrs
		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital		City, Town, or Lo akoma Park		Death		4c. County of Death Montgomery	1
		Social Security Number 6. Sex 7. Age (In yrs. last birthda)		Under 1 Year	If Under	Odlies I O D	hate of Dich	(MM/DD/YYYY) 9. Bir	thriage (State or
Funeral Director		218-13-0575 1 X _{M-2} _F 25	N	Months Days	Hours	1.6-		Foreig	
		Usual Residence of Decedent	Yrs.		_	1 11	u ₆ 23	, 1704	Citity, LID
any		10a. State 10b. County 10c. City, Town or L	Location						10d. Inside City Limits
Aaryland 28a-f show 1 at once.	5	MD Anne Arundel Annapo	lis						1 Yes 2 X No
Maryl.	Director	10e. Street and Number	10	of. Zip Code			10	g. Citizen of What Cou	ntry?
AID 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shountie event, the Medical Examiner must be notified at once.		1122 Riverboat Court			409			USA	
death wi or items	neral	1 X Never Married 2 Married Armed Forces?		ecedent of Hispa specify Cuban, N				14. Race - Amer White, etc.	ican Indian, Black,
ter de ", or i	Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes	s 2 X No	specify:			Specify:	White
hours afte 'natural'', Examiner	à P	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's U	Jsual Occupation	(Give ki		one	16b. Kind of Business/	Industry
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5036 within 72 iene. er than Medical	Ĕ	10	Aero	tech For				Downspo	uts
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene lant: If item 27 is marked other than ' or other traumatic event, the Medical	Be C	17. Father's Name (First, Middle, Last) Mark Farrell		18		Name (First na Hay		aiden Sumame)	
212 buld be Ment mark		19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Ad	dress (Street a				per, City or Town, State	e, Zip Code)
ore, MD es I and 2 sho of Health and If item 27 is	T	Mark Farrell - Father 11	22 R:	iverboat	t Coi	ırt, A	nnapo	lis, MD 2	1409
re, Legal Heal	ĺ	20a. Method of Disposition 20b. Place of D. Removal from State crematory				Date		20c. Location - City or	Town, State
Pages		4 Donation 5 Other Specify:	ıco1n	Cemete	ry	12/2/0)9	Brentwood	l, Maryland
Baltimore, ME permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traums	Ì	20 . 11 111		e and Address of					imore Ave.
	4	26 Part I Enter the disease of small indicate the leavest the death December 1	Gascl	h's Fune	eral	Home,	P.A.	Hyattsvil	1e, MD 20781
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not er failure. List only one cause on each line. Combine drugs	(Oxy	codone,	Älp	razol	am, a	nd	Between Onset and Death
*aminer		Immediate Cause (Final disease or condition resulting in death) a. Clonazepam) intox Due to (or as a consequence of):	xicat	CTOII					
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		23a,27,28a-1	<u>f,per</u>	rmE, g89	8 12	2/17/09	9 TT	22d Date of deliver	
rtifical	S S	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal d	death 3	Ectopic	pregnancy		23d. Date of deliver	Day Year
Box 68760 The death certificate I the attending physical for use as the bheat of the attending physical for use as the branch of the attention of the attentio	Physician/Me	4 Pregnant at time of death 5	Other	(Specify)					
that the de red by the detached f	吾	Part II. Other significant conditions contributing to death but not resulting in	the unde	erlying cause giv	en in Par	ti. I	23e. Did tol	pacco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	à			, , , , , , , , , , , , , , , , , , , ,			1 Yes	2 No 3 Pro	bably 4 Unknown
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Vital Rec ysician: The I his certificate I director, page	မ္မ	25. Was case referred to medical				Check only o			
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Sior Attend or death ector: by the	ä	2 Accident Investigation Fd 11/25/09 Fd 1			-			Areas and Number of D	ural Davida Niverbas City
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	١	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death			and place				
o the ithin or the o the or the or the or the	ledical	one) 2 Medical Examiner: On the basis of examination and/or inve	estigation,	in my opinion, o	leath occ	urred at the f	time, date a	and place, and due to t	he cause(s)
	ğ	29b. Signature and title of certifier		29c. License i				29d. Date signed (Me	
		W W IV 3		O.C.M	.E.			November 26, 2	.009
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S	Street I	Baltimore, M	D 2120)1		<u> </u>	
912	ate	31. Date filed (Month, Day Year) 32. Registrar's Signatus		Darminoie, M	2120				
Registi		NOV 3 0 2009 Denus B. Again							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Amend Items 23a,25 per me, g899,01/06/IVdhb Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 7:35 a November 14, Fletcher Gretchen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 6729 Conley Road Hyattsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 1 F Sept. 199-16-9739 86 17, Pennsylvania 1923 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be a cuffied at once. 1 ☐ Yes 2X No Director Maryland P.G. Hyattsville 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 6729 Conley Road 20783 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 Toldes

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Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 🛣 No Specify ۾ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William B. Smith Helen Durkin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Fletcher/Son 9H Laurel Hill Road, Greenbelt, MD 20770 20b. Place of Disposition (Name of Acemetery crematory or other place)
ATIING TON National
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 14, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spr 21. Signature of ∮uneral Service Lie Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic Airway Obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Airway Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): CERTIFICA of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? this certificate 1 ☐ Yes 2 🖾 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 250 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Divîsion 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and file of certific 29c. License number . Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Court-Ste. 200 - Largo, MD DO Leski lona 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 18 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Matthew Edward Fleming, Jr. 21 2009 4:30 AM Nov /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton 8. Date of Birth (Month, Day, Year)
Sept. 24,1930 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ⅓M 2 ☐ F Pennsylvania Director 159-26-5918 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evantine must be notified at 1 Ves 2 □ No Director Hurlock MD Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21643 307 Gannon Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 51 − 78 1 ☐ Never Married 2 ☑ Married Matthew Fleming Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Entrepreneur Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Ethel Lofland Matthew Edward Fleming, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 605, Hurlock, MD 21643 Mildred I. Fleming/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition h Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland Eastern Sh. Veterans 11/24/09 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transit law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. the 9 I Inknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes page 1 ☐Yes 2 ☐ No 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 140 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIO DUTCHMANS LROWLEY MD NOV 2 4 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 38787 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Joan 2009 Farrow 2220 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Vicon ico Salisbyll REGIONAL MINICAL Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🗑 F 217-05-9680 Director 90 09/25/1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h Counts 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Wicomico Salisbury 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 1801 Crawford Drive 21804 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2√No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "r. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Marketing Specialist Perdue Farms 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Robert McDorman Ida Tawes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. once. J. Irving Farrow/Husband 1801 Crawford Drive, Salisbury, MD 21804 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Manokin Presbyterian 11/14/2009 Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) .22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ncommo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. detached 9 I Inknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 TYes Completed page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? res 2 No certificate 1 □Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1.Xinpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 09 10 30. Name and ess of person who completed cause of death (Item 23a) (Type, Print) Jafar Sadia G. Carroll 51 31. Date filed (Month, Day, Yea) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 [] [] 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 P M November 9, 2009 THELMA DELORIS GAITHER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days 1 □ M 2 🖔 F 01/04/1929 DC 214-48-5900 80 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10h. County d other than "natural", or items 23a or 28a-f show event, it o Medical Examiner must be nofffled at 1 XYes 2 No Funeral Director MD Silver Spring Montgamerv 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with USA 20910 2411 Lyttonsville Road, #204 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Black Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Home Care Provider Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Lucille Wilson James L. Granger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 2411 Lyttonsville, Rd, #204, Silver Spring, MD 20910 Clayton E. Gaither - son 20c. Location - City or Town, State 20b Phace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem 12/07/09 Fort Myer, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home of Funeral Service 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the diseas shock, or heart failure. ease, or com ire. List only Approximate Interval Between ications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Findisease or condition resulting in death) **Physician** Acute ceretral vascular accident /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Heat Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-trar Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the I as IF FEMALE: use 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1X Yes 2 No 3 Probably 4 Unknown Metastatic Carinoma of Lung page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 X No I or Attending Physician: after death. Director: After this certifica 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: $4 \square$ Nursing Home $5 \cancel{N}$ Residence $6 \square$ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 11/10/09 D55522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Geard 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ack 17 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 756 AM 09 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Markland 140sprheil PG INFON 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Denin Republic Director 7.48-807 Usual Residence of Decedent 23a or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Washin NONE 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 20011 OMR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 DOMR 1 Nes 2 No Specify: If Yes. Give Specify: Dominican 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Uniemployed none Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ GARCIA JUANA 19a. Informant's Name/Relationship (Type, Print) Daughtu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4611 9th ST. N.W. Washington, O. L Zoull f Health aitem 27 i MARIAM or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit, Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Dumings GARCIA family Cem. 11-27-04 4 ☐ Donation 5 ☐ Other (Specify) Deminican Reputic 21. Sig Liture of Funeral Service Licensee 22. Name and Address of Facility the Hose & will have annes & 80 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cy Ed. Il Immediate Cause (Final disease or condition Physician/ SSINE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be rewithin 24 hours after death.

30 the Funeral Director. After this certificate has been signed by the attending physicis physicis physicise to be a filled in by the funeral director, page 2 should be detached for use as the burn the burn that the filled in by the funeral director, page 2 should be detached for use as the burn that t Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed No 1 🗌 Yes 2 🗎 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) .determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State NOV 17 Registrar

			1 - State of Maryland / De State of Maryland	epartment of Health Certificate of Deatl		al Hygier Reg. N	2009	38790
	Physici		Decedent's Name (First, Middle, Last) GAIL P. GEBERT			ate of Death onth vember	14, 2009	3. Time of Death 8:11 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location			c. County of Death	
abe "			202 Adclare Road	Rockville	ler 24 Hrs. 8. Da	ate of Birth	Montgomer	y place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthe	Months Days Hours	s Min. (M	fonth, Day, Yea	r) Cou	ntry) Lnois
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	ar Location			1	10d. Inside City Limits
	Aaryla f sho	ō						1 Argres 2 □ No
	r 28a-	Directo	Maryland Montgomery Rockv: 10e. Street and Number	10f. Zip Code		10g. (Citizen of What Cou	ntry?
	th with		856 College Parkway, #102	20850			United St	ates
	tems term	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Of If Yes, specify Cuban, Mexic 	Origin? (Specify Y can, Puerto Rican,	es or No- , etc.)	14. Race - Ameri Black, White,	
336	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23a or 28a-f show event, in Modical Evanting must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give 3 ☐ Widowed 4 🖼 Divorced Year or Dates:	1 ⊡Yes 2 ⊠ No <i>Speci</i>	ify:		Specify: Wh	nite
215-0036	2 hou		15. Decedent's Education 16a. D	ecedent's Usual Occupation		16b.	Kind of Business/Ir	
	ifiled within 72 h Il Hygiene. other than "natu rent, I'r Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during mile. DO NOT use retired)	iosi di warking		770 4 4	
12	iled w Hygier ther th nt, th		17. Father's Name (First, Middle, Last)	Secretary 18 Mod	ther's Name (First	t. Middle, Maid	NOAA en Surname)	
yland	id be f ental I ked of	To Be	Mack Gebert	13. 113	,	izabeth	,	or
Mary	shoul and M s mar	-		Mailing Address (Street and Nun				
Σ,	and 2 ealth: n 27 i	1		Adclare Road,				
ore e	ges 1 nt of H if iter or oth		12 Burial 2 Cremation 3 Removal from State	isposition (Name of crematory or other place)	Date		Location - City or T	,
Baitimore,	nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specify) Parklaw 2 Signature of Funeral Service Licenses	m Mem. Park 22. Name and Address of Fac			ckville,	Maryland
g	permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, Ins. once.		Alacha N lender	10 East Deer P				D. 20877
П			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.					Approximate Interval Between
-	Physician		Immediate Cause (Final diseases or condition a. Metastatic Breas	t Cancer				Onset and Death 14 Months
	/Medical Examiner		resulting in death) Due to (or as a consequence of)	:				
	ie .	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	:				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underflying Cause (Disease or injury that initiated events					
Š,	cate be executed physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of)	:				
	ficate be executed physician and s the burial-transit	dical	d					
BOX	w requires that the death certifi been signed by the attending should be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deliv	very
	death ne atte	Physician/Me	in the past 12 months? 1 Yes 2 XiNo 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
7. O	nat the d by th etach	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	an condendada a como elegar la De-	l 2	2a Did tobaca	o use contribute to	the cause of death?
ď,	requires that the been signed by th hould be detache	ē.	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Pai	et I. 2			bably 4 Unknown
cord	w requ	letec			2	4a. Was an	24b. Were aut	opsy findings available
r	ding Physician: The law h. h. After this certificate has b. funeral director, page 2 s1	Completed				autopsy performed	prior to co death?	ompletion of cause of
	stan: " ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Pla	ace of Death (Che	Yes 2 🔀	NO I TES	Daughters
5	Physician: this certific ral director,	ျာ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp					(fy) Residence
	ding F h. After funer	tion:	27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Describe how in	jury occurred	
DIVISION	al or Attending F s after death. I Director; After d in by the funer	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		28f. Le	ocation (Street	and Number or Rui	al Route Number,
5	s afte	Certification:	4 ☐ Homicide determined building, etc. '(Specify)'			ity or Town, St	ate)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.					
	o the	Mec	29b. Signature and title of certified	29c. License numbe	er	29d.	Date signed (Month	Day, Year)
	10		Chry Wkmduch	D 37236	5	No	ovember 1	6, 2009
	1 -		30. Name and address of person who completed cause of death (Item 23a) (T	/pe, Print)				
			Carolyn Hendricks, M.D., 6410 Rockle 31. Date filed (Month, Day, Year) 32. Registrar's Signature	edge Drive, Bet	thesda, M	iarylano	1 20817	
	Sta Registr		NOV 1 7 2009 Sentin B. A	ares				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 [] [] 9 1 Decedent's Name (First Middle Last) 2. Date of Death November 13, 2009 7:00 A M **Physician** Joseph GOVERMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Bowie 2213 Hyde Lane Hours Min. 8. Date of Birth (Month, Day, NoV. 99. 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1929 Washington, DC 1 □ M 2 □ F 80 578-36-8703 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner must be nutified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 V Yes 2 □ No Director Prince Georges Bowie Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20716 2213 Hyde Lane Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bellman Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Bressler Abraham Goverman ဂ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2213 Hyde Lane, Bowie, MD 20716 19a. Informant's Name/Relationship (Type. Print) Gloria Goverman, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 11/15/09 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service 1003 Forchinskyss Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 Approximate Interval Between Onset and Death 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a consequence Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) the 9 Unknown icate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 X 1 □Yes 2 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 30 Name 31. Date filed (# State Registrar

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In a "Modical Exercitive In set to notified at another. Ò

Saltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burta-fransit completely filled in by the funeral director, page 2 should be detached for use as the burta-fransit 1.5

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 08 2009 Nov 5:32 Jean Anita Graunke 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Adelphi Hillhaven Nursing & Rehab Prince Georges 8. Date of Birth (Month, Day, Sept. 4, 1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 1 ☐ M 2 🗓 F Months Days Hours Min. 395-22-5792 82 Wisconsin Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Columbia **Funeral Director** Maryland Howard 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8989 Buckskin Court 21045 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. ☐Yes 2 Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: ģ 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ernest Melvin Quandt Ethel Irene Dahlke ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8989 Buckskin Court Columbia, Maryland 21045 Vernon H. Gruanke -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MetropolitanCrematory 11/9/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 he 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrythmia 5 minutes disease or condition resulting in death) Due to (or as a consequence of): Coronary Artery Disease 15 years Sequentially list conditions, if only locality cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Chronic Obstructive Pulmonary Disease 15 years Due to (or as a consequence of); Pneumonia Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Rheumatoid Arthritis; Autoimmune Disease; Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ Xio 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17843 November 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vivek C. Vaid, M.D. 3311 Toledo Terrace, B102 Hyattsville, Maryland 20782 31. Date filed (Month 32. Registrar's Signature State Barks reur Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Bertha GOLDMAN November 2009 4:40 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Hospice Casey House
5. Social Security Number | 6. Sex | 7. Age (In yrs. Ie Rockville Montgomery 9. Birthplace (State or Foreign 8. Date of Birth July 24, 1922 If Under 1 Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 □ yF Washington, DC 87 Yrs. Director 579-24-9128 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
The street of Health and Mental Hygiene.
The street and the than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or other traumatic event, Ite Madical Examiner in a the natural or other traumatic event, Ite Madical Examiner. 1 □Yes 2 □ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 United States 15211 Elkridge Way #201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Myerson Benjamin Dekelbaum ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515 Margaret Drive, Silver Spring, MD Carl Goldman, Son 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 11/13/09 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) Torchinsky Hebrew Funeral Home 2000 20012 254 Carroll St., NW. Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. End Stage Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Severe Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diss to (or as a consequence of) law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) s been signed by the should be detached Ö 9 I Inknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page , performed? 1 □Yes 2 No 1 ☐Yes 2 ☐ No certificate 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death ospital or Attending I hours after death. 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation I Director: d in by the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Directory

completely filled in by To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier J. Kouch chou, mis D63748 November 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

Year)

Marks!

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 15, Guerricagoitia 2009 2:46 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Spain 1 M 2 - F Days Hours Min. Feb. 17, Year 1927 Director 488-46-5214 82 Yrs. Usual Residence of Decedent fshov 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1413 Crestridge Drive 20910 Spain 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 0. Black, White, etc. 1 Never Married 2 Married ğ 1 X Yes 2 ☐ No Specify: Spanish White "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 27 is marked other than "r World Health Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Technical Officer Organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jose M. Guerricagoitia Consolacion Serrano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s it of Health a If item 27 i Gladys Guerricagoitia/Wife 1413 Crestridge Drive, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 😿 Cremation 3 🗌 Removal from State Nov.20 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death acute Immediate Cause (Final Physician/ Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2007 Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 2 No the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XX No 1 Yes ဂ္ 1 Inpatient 2 K ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After or Attending X Natural 5 Pending 1 Yes 2 No Accident Accider
Suicide Investigation To the Hospital or Attenct within 24 hours after death To the Funeral Director; the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) qотріете filled in by determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H58874 November 17, 2009 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Avenue, Kensington, MD 20895 Bradley Hunter, D.O. 31. Date filed (Month, Day, Year) Registrar's Signato State 18 2009 Registrar

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 November 15. 5:30 p Paul Owen Glass 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **№** M 2 🗆 F Hours April 22, 76 Michigan 227-38-7926 193 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Daleview Drive 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 □ No If Yes, Give 1955- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 No ve 1955-59 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Glass Dimple Bell Owen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 594 Valley Street, Maplewood, NJ 07040 19a. Informant's Name/Relationship (Type, Print) Mary Devon O'Brien/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Nov. 17 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 of Funeral Service-Signatur 27 Name and Address of Collylins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Respiratory Failure

Physician Medical **E**xaminer

Examiner

by Physician/Medical

Be Completed

2

Certificate:

Medical

only one) 29b. Signatu

31. Date filed (Month, Day, Year

Harold V. Lawson, MD

NOV 18

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

shov

ral", or items 23a or 28a-f sho Examiner must be notified at

or

"natural",

of Health and Mental Hygiene.

Item 27 is marked other than "nature other traumatic event, the Medical

Department of Health an Important: If Item 27 is any injury or other three once.

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transi certificate be Box 68760 the nse ó the Division of Vital Records, P.O. should be To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be

disease or condition	a medipitately ratiate										
resulting in death)	Due to (or as a consequence of): Sepsis										
Sequentially list conditions, if any, leading to immediate output. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Urinary Tract Infection										
	d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year								
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?								
		24a. Was an autopsy performed?									
25. Was case referred to medical examiner?	26. Place of Death (Chec	ok only one)									
1 Yes 2 No	Hospital: 1 【 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 Residence	6 ☐ Other (Specify)								
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 \(\text{Yes} \) 2 \(\text{N} \) No	ry occurred									
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)								
29a Certifier 1XX Certifying Physi	ician. To the best of my knowledge, death occurred at the time, date and place, a	nd due to the cause(s)	and manner as stated								

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Correlation Nurse Pragnoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D67589

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

November 17, 2009

29c. License number

CHMH 17 Few 7/2006

State

Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Physician/ Gittleson Nathan November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 😿 M 2 🗆 F Hours 0972671922 Director 87 578**-**16**-**3479 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director Bethesda Maryland | Montgomery 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 5450 Whitley Park Terrace, Apt. 20814 items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces: Black, White, etc. 0. 1 Never Married 2 Married Completed by 1 K Yes 2 If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: "natural", 3 Midowed 4 Divorced WWII Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. 4 Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Gittleson Eva Dorfman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r Gary Gittleson, son 10226 Sweetwood Avenue, Rockville, Maryland permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gdns | 11/17/2009|01ney, Maryland 21. Signature f Fun Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rockville Pike, Rockville, Maryland Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final Priysician/ disease or condition resulting in death) GΙ Bleed Medical Due to (or as a consequence of): Examiner Coagulopathy Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury g physician and as the burial-transi Atrial Fibrillation that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atte in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a detached f 9 Unknown us been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an has , page 2 autopsy perform Heson, Nathan To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 K No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🕱 No ပ 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

2009

4:00

9. Birthplace (State or Foreign

Washington, DC

White

Demolition

10d. Inside City Limits

1X Yes 2 No

20850

20852

Year

Approximate Interval Between Onset and Death

Dav

29d. Date, signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 20814 Suburban Hospital, 8600 Old Georgetown Rd, Bethesda, **ORIGINAL**

State Registrar

4 0 29b. Signature and title of Gerti

(Month, Day, Year) NOV 18

Name and add

Ann

Goetz

7. Age (In yrs. last birthday)

1 - State Registrar

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Golden Living Center

Mary

5. Social Security Number

Certificate of Death

4b. City, Town, or Location of Death

Days

Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Birthplace (State or Foreign Country)

10d. Inside City Limits

1√2 Yes 2 □ No

8:10 P M

Allegany

Maryland

2009

USA

Home

Cumberland, MD

23d. Date of delivery

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Nown 62 12, 2009

Dav

24b. Were autopsy findings available prior to completion of cause of death?

2 No

21502

Approximate Interval Between Onset and Death

there

14 Race - American Indian

White

4c. County of Death

2. Date of Death

November 10,

Day

Registrar DHMH 17 Rev 1/2001

Macs

within 24 hours a

Medical

State

2 Accident

3 Suicide

29a Certifier

4 - Homicide

(Check only one)

29b. Signature and title of ci

NOV 12

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Vikramaditya Poonai, M.D., 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 TYes

LC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D36766

924 Seton Drive, Cumberland, MD

2 No

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Mary		rtificate of		Re	g. No. 200	0 38705
ī	Physici		1. Decedent's Name <i>(First, Middl</i> e, Las Naomi	Marie	Galli	her		2. Date of Death Month Novembe	Day Year	3. Time of Death 1:35 A M
A TOP STATE OF THE PARTY OF THE	/Medio		4a. Facility Name (If not institution, give			2.	r Location of Death		4c. County of Dea	Legany
	Funeral Director		215-44-7796	ox □ M 2፟ØF 7. Age (In 63	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/22/1		rthplace (State or Foreign ountry) aryland
	Maryland t-f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County MD Allegar		. City, Town or Lo	cation Frostbu	~g			10d. Inside City Limits 1 □XYes 2 □ No
	in with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 162 W. Mechani	c Street		10f. Zip Code	21532	10	og. Citizen of What C USA	ountry?
036	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In important: I fire X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Moulcal Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	vithin 72 hou ene. than "natur in Mouler! I	Completed	15. Decedent's Edit (Specify only highest grad	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Secretary	ation during most of worki d)	ing	Univers	s/Industry
א א	other	Be Co	17. Father's Name (First, Middle, Last)			secretary	18. Mother's Name	e (First, Middle, N		ı cy
ylar	Ould be Ments arked atic ev	TO E	Glenn	Stewart	Stanton	1	Gladys	Ma	rie	Griffiths
, Maryland	and 2 she salth and 1 27 is m er traum		19a. Informant's Name/Relationship (7 Donald H. Galli)		11.7	•			City or Town, State, tburg, MD	Griffiths State, Zip Code) MD 21532 City or Town, State Pland, MD eral Home, P.A
Baltimore,	nt. Fages 1 and the criment of He criment. If item injury or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemoval from State	20b. Place of Disposition (Name of Date	6/2009		nd, MD		
ם מ	Deparation of the parameter of the param		21. signature of Funeral Servic Licens		land, MD	21502				
E	Physician: The law requires that the death certificate be executed with this certificate has been signed by the attending physician and injury of a detached for use as the burial-transit of a second part of the control of the contr	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	nsequence of):	56550	est Con		-	Interval Between
r. O. BOX 00/00,	ires trait fire death centificate by signed by the attending physicil be detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	d	Fetal death 3 [of death 5 [☐ Ectopic pregnanc☐ Other <i>(specify)</i> _			23d. Date of do Month	Day Year
us,	w requires in s been signed should be de	þ	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
al Records,	his certificate has be director, page 2 sh	Completed	25. Was case referred to medical				26. Place of Deat	24a. Was ar autops perforn 1 □ Yes 2	y prior to ned? death? ! ☐ No 1 ☐ Ye	autopsy findings available completion of cause of
ISION	death. ctor: After y the fune	Certification: To Be	nce 6 NOther (Sp w injury occurred	Mother's ecity) Residence Gural Route Number,						
5	within 24 hours after death To the Funeral Director: completely filled in by the		4 ☐ Homicide determined 29a. Certifier 1 ☒ Certifying Ph	building, etc. (Spysician: To the best of my		h occurred at the ti	me, date and place	and due to the c		as stated.
:	in 24 h he Fun pletely	Medical	(Check only 2☐ Medical Examone)	iner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my	opinion, death occur	red at the time, d	ate and place, and du	ue to the cause(s)
, 	Mithi Comp	Ž	29b. Signature and title of certifier	ni ho		29c. Licens	e number 565	29	od. Date signed <i>(Mor</i> November	
•	MAS		30. Name and address of person who can thony J. Bo				al Highwa	ıy, LaVal	Le, MD 21	502
	Sta Registr		31. Date filed (Month, Day, Year) NOV 16 2009	62. Registrar's S	ignature Law	41				

Baltimore, Maryland 21215-0036

	Phys
	/Me
mark.	Exa
Division of Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.
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	thi th

		. For State	r Print in Black of Maryland / D	epartme	ent of Health	n and M	-	_	
		State Registrar		Certifica	ate of Deat			1. No. 200	9 38799
Physicia /Medica	_	1. Decedent's Name (First, Middle, Last) Josephine Remsburg Gr:	imm				2. Date of Death Month Novembe	Day Year 17 200	
Examine		4a. Facility Name (If not institution, give street and	number)	4b. Ci	ty, Town, or Locatio	on of Death		4c. County of De	ath
4		1134 Luther Dr.	1 = A - 0 - 1 - A 6 - A		gerstown Der 1 Year If Und	der 24 Hrs.	O Data of Dist		on County
Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birth	rs. Month		s Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
Director	}	Usual Residence of Decedent	86				Oct. 21	,1923	ryland
ylanc now		10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
a-fs	cto	Maryland Washington Cou	ınty Hagersi	town					1 ☐ Yes 2 ☐ No
or 28	Director	10e. Street and Number		10f.	Zip Code		100	g. Citizen of What	Country?
ath w		1134 Luther Drive			21740			U.S.A.	
er de	Funeral	Armed	ecedent Ever in U.S. Forces?	13. Was De	cedent of Hispanic pecify Cuban, Mexi	Origin? (Spe can, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
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hin 7%	ple	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	(Give kind of life. DO NOT	work done during m use retired)	nost of workin	g		
d wit /gien er th	Be Completed	1		ecreta				Bank	
should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Exercities must be notified at	Be	17. Father's Name (First, Middle, Last)			18. Mo	other's Name	(First, Middle, Ma	aiden Surname)	
ould I Men narke	ို	Ernest Ellsworth Remsh	0					Remsbur	(3)
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Exprince mones.		19a. Informant's Name/Relationship (Type. Print)		Ü	ess (Street and Nur				, Zip Code)
1 and Healt em 2		Grady M. Grimm-husband 20a. Method of Disposition	1 11.	34 Luti	ner Dr. H		own, MD	21/4() Oc. Location - City	or Town, State
Pages 1 nent of H int: If iter iry or oth		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro				44 0		ŕ	
artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Kest H	aven C	emetery and Address of Fa	cility D	J-2009 H	agerstow	n, Maryland
permit. Departi Import any inj once.		Dunala NS	Z. in	1331	Footom I	Doug	glas A.	Fiery Fu	neral Home ,MD 21742
		23a. Part 1. Enter the disease, or complications th	at caused the death. Do no	ot enter the m	node of dying, such	as cardiac o	respiratory arres	gersrown	Approximate Interval Between
Physician		shock, or head failure. List only one cause of Immediate Cause (Final	Maligr	nant	C'brok	xtio (cotoma		Onset and Death
/Medical		disease or condition resulting in death) a Due	to (or as a consequence of		101010	1 2/1	7101110		+
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	gic	d							
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death e atte d for i	icia	in the past 12 months?	ve birth 2 Fetal death regnant at time of death	3 ☐ Ectopi 5 ☐ Other	c pregnancy (specify)			Month	Day Year
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sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?			Othor:	ace of Death	(Check only one)	
Phys r this ral dir	၉	ILI fes ZICNIO	Inpatient 2 ER/Out ate of Injury 28b. Ti	<u> </u>	DOA 4 28c. Injury at		ne 5 X Resider 8d. Describe hov	ce 6 Other (S	pecify)
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al or after I Dire	Certification: To	4 Homicide determined by	ullding, etc. (Specify)				City or Town,	State)	
pspita hours unera ly fille		29a. Certifier (Check only 2 Medical Examiner: On the							
he He in 24 he Fu	Medical		nanner stated.			geath occurre			
To t To t	Σ	29b. Signature and title of certifier	MUD		29c. License numb		29	d. Date signed (Mo	inth, Day, Year)
		1 9 0			D6890	15		11/19/	7
211-12		30. Name and address of person who completed of	ause of death (Item 23a) (1	Type, Print)	Haperston	n Aan	217/16)	
3H - 12		101.0	2. Registrar's Signature		J)	-1/40		
Registra		NOV 2 0 2009	X	1.	N				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 38800 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 17, 2009 Richard Hamilton Grimes November 5:49 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 212 South Artizan Street Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 3, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**XX**M 2□ F Months Days Hours Min. 214-14-6357 Maryland **Director** 90 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28e. - any Injury or other traumatic event, the Maryland ones. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MXYes 2 □ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 South Artizan Street 21795 Funeral USA 12. Was Decedent Evering I.S. Armed Forces? 1941— AMYes 2□No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes XX No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Trucking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Benjamin Henry Grimes, Sr. Mary Elizabeth Houpt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred L. Grimes - Wife 212 S. Artizan St. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 11-21-2009 Williamsport, Maryland Greenlawn Mem. Park 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Fineral Service 425 S.Conococheaque St. Williamsport, MD 21795 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myelosenous A cute 2 mont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

For the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 🖪 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 🗆 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) 29b. Signature and title of certifier 41667 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Compos Hejestrun Micco 11/10 mock 31. Date filed (Month Nay, Year) 9 32. Registrar's Signature State

Registrar

09-08967 Kor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rey Deone Ho		Since State	tate of Maryla	and / Depa	rtment of tificate of	Health	and M	ental			2009	3880
Physici		Registrar 1. Decedent's Name (First, Midd	fle,Last)		incate of	Dealin			2. Date of De	Reg. No.		me of Death
edical Exami		KOREY	DEONE HO			0.1. 7	11	ing of Do		Day Yea er 18, 2009		238 hrs
		4a. Facility Name (if not instituti	on, give street and no lace	umber)	4	b. City, Town Montgor			aui	Montgor		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1		Jnder 24l	_	Birth (MM/DD/YYYY	() 9. Birthplace Country)	e (State or Foreign
Director		578-19-1531	1XM 2F	19	Yrs.	Months	Days H	lours N	March	19,1990		yland
x		Usual Residence of Decedent		110c City	Town or Location	on.					10d.	Inside City Limits
w an		10a. State 10b. County MD Mont	gomery		Iontgame		llage				1 [XYes 2 No
Maryland 28a-f show any d at once.	ctor	10e. Street and Number			- Jane	10f. Zip Co				10g. Citizen of W	hat Country?	
he Ma or 28 ified a	Director	9409 Hickory	View Pla	c e		20	0886			U.S.	A.	
nore, MD 21215-0036 ages I and 2 should be filted within 72 hours after death with the Maryland and Fleath and Mental Hygiene. FI filten 27 is marked other than "naturaly, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	ral	11. Marital Status		cedent Ever in U	.S. 13. Was	s Decedent o	of Hispanic	Origin?	(Specify Yes or Nerto Rican, etc.)	No- 14. Race Whit	e - American In te, etc.	idian, Black,
death or iter	Funeral	1X Never Married 2	1 Yes	ZX No					3/10 (110011)	Specify:	Black	b
s after iral",	by I	3 Widowed 4 D	ivorced If Yes, Give Ye or Dates:		16a. Deceden	Yes 2	7		of work done	16b. Kind of B		
2 hour "natu	Completed	Elementary/Secondary (0-12		(1-4 or 5+)		ost of workin						
036 ithin 7 ne. rethan	ld in	10th		_	Un	emplo	-			None		
215-0036 be filed within 72 ntal Hygiene. rked other than "ent, the Medical	ပ္ပိ	17. Father's Name (First, Middle Vincent Too		r						e, Maiden Surname		
2121 ould be i Mental marke ic event	o Be	19a. Informant's Name/Relation			19b. Mailing	Address (lumber, City or Tox		Code) 20886
MD 2 nd 2 shou alth and 1 m 27 is n	-	Terry Hollo								ontgomery	' Villa	ge, MD
Te, I and I Healt Fitem		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Removal		Place of Dispos crematory or oth		of cemeter	ry,	Date	20c. Location	- City or Town	ı, State
MOI Pages nent of ant: I	Ш	4 Donation 5 Other	Specify	AN	Souls				1/27/09		town, I	
Baltimore, permit. Pages I an Department of Hec Important: If ite injury or other tr	W	21. So ature of Funeral Servi	e Licenser	ud						FUNERAL ckville,		
Physician		23a. Part I. Enter the disease,									eart Ap	pproximate Interval
Madical		failure. List only one cause Immediate Cause (Final diseate	se in each line.	drug (m							l B	Death
kaminer	Ì	or condition resulting in death)	Due to (or as	a consequence	of): compl	icated	by l	rono	hopneum	onia		
	ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	of):							
	mine	cause. Enter Underlying Cause (Disease or injury that initiated	se c.									
ted of	Examin	events resulting in death) Las		a consequence								
e executed cian and riial - transi	dical	X UNPENDED	X AMENDED	23a,per 23a,27,	ME g89 28a-f,p	9 1/29 ermE,	/10 1 g898	TT/ 4	ia & 28f 17/09 TT	, per ME	g901 3	3/11/10 TT
Box 68760, death certificate be the attending physic of for use as the bur	sician/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes	s, outcome of pre	gnancy	etal death		Ectopic pr		23d. Date Month	of delivery Day	Year
x 68 h certi tending	iciar	past 12 months?	4 Pre	gnant at time of o	looth	ther (Specif						į
D.O. BOY that the deatl ned by the att detached for	Phys	1 Yes 2 No 9 Part II. Other significant con		nown to death but not	reculting in the	underlying c	ause niver	n in Part I	23e. D	id tobacco use cor	ntribute to the	cause of death?
, P.O. ires that the signed by I be detach			unions commonny	to death but not	resulting in the	anaonying a	a 200 g o.			Yes 2 No	3 Probably	y 4 🗸 Unknown
ords, w require s been sig	Completed	-							24a. W	/as an 24b		sy findings available of
Records, The law require ficate has been si	QE	Ü								erformed? es 2 No	death? 1 ✓ Yes	2 No
Vital Reco ysician: The law his certificate has director, page 2 s	ပြ	25. Was case referred to med				26			neck only one)			
Vita hysick this ce		1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien				lursing Home 5		Other: Sc	ene
Division of Vital ral or Attending Physician: rs after death. al Director: After this certicled in by the funeral director	l ii	27. Manner of Death 1 Natural 5 P	(Mo	ate of Injury onth, Day,Year)	28b. Time of	. ,	ic. Injury a			ibe how injury occi	ined	
SiOI Atten r death ector:	cati	2 Accident	vestigation 28e P	11/18/09lace of Injury - At	Fd 10:	35 pm				on (Street and Nur	mber or Rural I	Route Number, City
Divi	ertification:	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	ould not be etermined (Speci	1					P1. M	ontgomer	Villa	Route Number City ry View age, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis Tombeelv filled in by the funeral director; sake 2 should be detached for use as the burit.	၂ပ	20a Certifier	Physician: To the lixaminer:On the bas	pest of my knowle	edge, death occu	urred at the t	ime, date	and place	e, and due to the	cause(s) and mann	ner as stated.	ause(s)
To the Within To the	Medical	one) 2 Medical E	and manne	er stated.	and/or investige		License n				igned (Month,	
	≥	29b. Signature and title of cer	will 11	<i>a</i>			O.C.M.				er 19, 2009	
		30. Name and address of per	son who completed o	ause of death (Ite	em 23a)							
		Pamela E. Southall	, MD Assista	nt Medical Ex	kaminer 1	-	Street, E	Baltimo	re, MD 2120	1		
Regi	State		7 2009	Registrar's Signa	ature pa	Red						
ixey		140 4 %	- <u></u>	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH G898 12/2/09 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HUGILL MICHAEL HILLP /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. Çity, Town, or Location of Death Examiner MONTGOMERY KENSINGTON CUSHING 5007 If Under 1 Year | If Under 24 Hrs. 6. Sex. 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 579.86.1239 Months Hours Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State MONTGOMER 1XYes 2 □ No ENSINGTION Director 10f. Zip Code 20895 10g. Citizen of What Country? 45+149 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. WHITE 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry SAMANAGER/ADMINISTRATION Elementary/Secondary (0-12) MASTERS RIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father Name (First, Middle, Last, Be DOROTHY SAVMONIS ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address Street and Number or Prural Route Number, City or Town, State, Zip Code) BETHESDA, MD 20817 8701 KANBURNES 20b Place of Disposition (Name of cemetery, crematory or other) 20c Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11/12/2009 IVERDALE KIVERDALE PARK 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

RIATERUNA

814 UPSHUR 21. Signature of Funeral Service Licenses ERAL SERVICES, elto a. Hacket STNO WASH. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR BUSEASE Physician ATHEROSCLEROTIC /Medical Due to (or as a consequence of): Examiner Acade ROBABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Dyslipidemia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA P After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death Injury 1 🔣 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 009 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Connecticut Are, KENSINGTON, MD LSKY Deborah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 12 2009 eneus Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nowth 14, 2009 Elias 0222 **Physician** Ghattas Hajjo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 75 Yrs. 6. Sex **Funeral** Months Days 11XM 2□ F 349-44-6976 12/05/1933 Palestine Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 TXYes 2 □ No MD Montgomery Gaithersburg Director 10f. Zip Code 20877 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 USA 466 West Deer Park Road Funeral 14. Race - American Indian permit, Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items: any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Self employed Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Meladeh Harb Ghattas Hajjo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Hajjo/Son 714 Rockaway Court San Diego, Ca. 92109 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 □ Cremation 3 □ Removal from State Gate of Heaven 11/18/2009 Silver Spring,Md Other (Specify) 4 □ Donation rvice Líce PATETY AD RENTWALDI FUNERAL SERVICE, P.A. 21. Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VAJCULAR 15 CHEMIA Physician CEREBRAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate l 2 7 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **201**6 1 Impatient 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After t Certification: Hospital or Attending (Month, Day Year) 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death, 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20057124 11/14/09 sew, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Truong Bao

NOV 17 2009

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature.

10110 Molecular Dr. Rockville, Md. 20850

DHMH 17 Rev 1/2001

1 - For State Registrar

	Physicia	ın	Elizabeth Anita						,	Month	Day 7, 2009	Year	9.30 - M
	/Medic		4a. Facility Name (If not institut		ımber)		4b. City, Town, or	Location		MOVATIVET		nty of Death	8:30 p ™
1	Examin	er	Iorien Nursing &					nt Air				arroll	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under	-	8. Date of Bir (Month, Da		9. Birthp	place (State or Foreign
	Director		579-09-4201	1 □ M 2 X F	93	Yrs.	Months Days	Hours	Min.	May 11,		Cour	New Jersey
- pilities	per replace Strateg		Usual Residence of Decedent										
	laryland show ed at		10a. State 10b. Coun	ty	10c. City,	Town or Lo	ocation					1	10d. Inside City Limits
	Mary -f sh	to	Maryland	Carroll			Mount Airy						1 X Yes 2 No
	the 28a notii	rec	10e. Street and Number	- COLLINS			10f. Zip Code				10g. Citizen o	f What Cour	ntry?
	with the true		713 Midway Ave	mie			217	71			USA		
	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status		cedent Ever in U.S	. 13.	Was Decedent of H		rigin? (Spe	cify Yes or No		ace - Americ	can Indian,
	iner	튑	1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2	Armed F	orces? 21⁄2 No					Rićan, etc.)	BI	lack, White,	etc.
36	ırs al	by	3√□ Widowed 4 □ Divorce	If Yes, G	ive		1 ☐ Yes 2 🗷 No	Specify:	:		Spec	ify: Wh	nite
ö	tura stura	ed	15. Deced	ent's Education	- 4	16a. Dece	dent's Usual Occup	ation			16b. Kind of	Business/In	ndustry
15	c + 0	Completed		hest grade completed)	(1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during mos i)	st of workir	ng	1		
12	filed within Hygiene. Ither than "	E O	Elementary/Secondary (0-12 12) College ((1-40/ 5+)	Caf	eteria Supe	erviso	r		ט	.S. Gov	vernment
P	filed Hygid Sther ent, ti	O	17. Father's Name (First, Middle	le, Last)				18. Moth	er's Name	(First, Middle	Maiden Surna		
an	should be filed within a Mental Hygiene. marked other than matic event, the M	To B	Norman Reed					Flo	orence	Heitzma	n		
Maryland 21215-0036	2 should and Men is marke aumatic	F	19a, Informant's Name/Relatio	nship (Type, Print)		19b. Mailie	ng Address (Street	and Numb	er or Rura	I Route Numb	er, City or Tow	n, State, Ziı	o Code)
Za	2 6 5 6		Elizabeth Blake			1017	Parade Lar	ne. Mt.	. Airv	. MD 217	71		,
ď.	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	,	20b. Pla	ace of Dispo	osition (Name of			ate	20c. Location	n - City or Tr	own, State
٥	nt of nt of it		1 X Burial 2 ☐ Cremation		n State ce	metery, cre	matory or other plac e aven Cemet e		Nov.		Ci I	·	Name of Second
Baltimore,	Tan tan tan tan tan tan tan tan tan tan t		4 □ Donation 5 □ Other				2. Name and Addre		200	9	Sliver	spring,	Maryland
Ba	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tonce.		21. Signature of Funeral Service	- (());a	el.	-	Francis J. 500 Univers	Ç01 <u>1</u>	ins Fu	neral Ho	me Inc.	. MD 30	2001
		- 1	23a. Part1. Enter the disease,	or complications that	dt Codt beeuwee	Do not on						, 140 20	
	Physician	Ш	shock, or heart failure. L	ist only one cause on	each line.	Donoten	ter the mode of dyli	ig, sucii as	s cardiac o	r respiratory a	rrest,	J.	Approximate Interval Between Onset and Death
,			Immediate Cause (Final disease or condition resulting in death)	a. Stat	us Post Pne	eumonia	1						10/2009
	/Medical Examiner		resulting in death)	Due to	o (or as a conseque	ence of):					10/2009 1 month		
	LXummer	_	Sequentially list conditions,	D	lure To Thi								1 month
¥ .	p it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseque	ence or):							
	ecute and trans	Cam	that initiated events resulting in death) Last	C. 3 ±	ertension (or as a conseque								1 year
80,	e ex					,							
87	ate t	dica		d. Hypo	othyroidis	n							l year
Box 68760,	death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical	IF FEMALE:										
30	ath o	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	utcome pf pregnan birth 2□Fetal	death 3	⊒Ectopic pregnanc	/				Date of deliv Month	rery Day Year
		Sici	1 ☐ Yes 2 🗷 No	4∐Preg 9□Unki	nant at time of de nown	ath 5[Other (specify)						54)
P.0	w requires that the d been signed by the should be detached	Physi	9 ☐ Unknown							00- Pid		-4.71 4 - 4 - 4	No and a state of
	gnec gnec	β	Part II. Other significant cond Depression, Mil	_									the cause of death?
Records,	equir en si ould					oopozo.	15, 1110011			1	Yes 2∐No	3 ∐ Proi	bably 4 XUnknown
၁၁	law r as be 2 sh		Anemia, Hyperli	pidemia, Dia	betes—Type	II				24a. Was		o. Were auto	opsy findings available ompletion of cause of
<u>~</u>	: The lav cate has	Completed								perfo	ormed?	death? 1 ☐ Yes	2 No
or Vital	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detached.	Be C	25. Was case referred to medi	cal				26. Plac	e of Death	(Check only			
>	nysician: nis certific director,	ToE	examiner? 1 Yes 2 X No	Hospital: 1	Inpatient 2 E	R/Outpatie	nt 3□ DOA Oth	er: 4□N	ursing Hor	me 5 ☐ Resi	dence 6 🛎 C	Other (Speci	Assisted ify) Living
0	g Ph		27. Manner of Death	/8.40	e of Injury onth, Day Year)	28b. Time o	of 28c. Inju				how injury occ		- III v III g
<u>ö</u>	Attending r death. ector: After by the fune	ig	1 Natural 5 Pen 2 Accident inve	stigation (Mo	min, Day rear)	injury		Yes 2□]No				
Division	i or Attendafter death Director:	<u>ië</u>	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rmined Zoe. Flat	ce of injury - At hon ding, etc. (Specify)	ne, farm, st	reet, factory, office		2		Street and Nut wn, State)	nber or Run	al Route Number,
Ö	al or	Certification:	Tomode	Buik	umg, etc. (opecny)	,				Only or 10	wii, Olale)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral			ying Physician: To th									
	e Ho 1 24 l ie Fu	Medical	(Check only 2 ☐ Medic one)	cal Examiner: On the and ma	basis of examinati nner stated.	on and/or in	nvestigation, in my	opinion, de	ath occurr	ed at the time	, date and plac	e, and due t	to the cause(s)
	Nithir Somp	ğ	29b. Signature and title of conti	fier	-00		29c. Licens				29d. Date sig		
	10) (selle	2 Ko	elle.	n 14	D	D54	4749		November	10, 20	009
	10		30. Name and address of pers	on who completed cau	use of death (Mem	2Ba) (Type	Print)						
			Allen Reilly,	,			ad, Baltim	ore, M	D 2122	8			
	Sta	te	31. Date filed (Month Day, Yes										
	Registr		31. Date filed (Month, Day, Yet	12 2009	Registrar's Signati	A. 1	parked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9

38805

DHMH 17 Rev 1/2001

			For State	State	of Marylan		artment of h		ınd Mei			009	388	306
			Registrar 1. Decedent's Name (First, Middle	a last)			Timodic or	Douin	2.	Date of Deat	-	005	3. Time of	
	Physicia /Medic		Richard C.	Horn					No	Month ovember	Day 5 ,	2009	8:32	
	Examin	er	4a. Facility Name (If not institution	-	umber)		4b. City, Town, o		f Death			4c. County of Death		
~			7013 Wick Lane			to a distribution of	Rockv:				Montgomery irth 9. Birthplace (S			or Foreign
	Funeral Director		5. Social Security Number 215-54-8684	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 72		Months Days	Hours	Min	Date of Birth (Month, Day, ine 22,	Year) 193	Coul	ntry)	n roreign
			Usual Residence of Decedent											
	arylan show	_	10a. State 10b. County			y, Town or Lo						1	0d. Inside C	ity Limits 2 X No
	Ba-f s	ç	Maryland Montg	omery		Rockvi	_							28110
	vith th	Ë	10e. Street and Number				10f. Zip Code			1		n of What Cour		
	s 23a	eral	7013 Wick Lane	10 Was Do	cedent Ever in U.	C 121	20855 Was Decedent of 1	Hioponio Orio	nin? (Specif	v Ves or No-		ited St		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evarinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marriad 3 ☐ Widowed 4 ☐ Divorced	ried Armed F 1 □Yes If Yes. G	Forces? 2 ∑ No Sive		if Yes, specify Cub	an, Mexican,	, Puerto Ric	can, etc.)		Black, White,	etc.	
9-0	2 hou	ted	15. Deceden	t's Education	n	16a. Dece	dent's Usual Occu	pation	of working		16b. Kind	of Business/In	dustry	
21	thin 7 ne. an "r	Completed	(Specify only highe: Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retire		or working			_		
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Z	thould nd Me mark matic	2	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree					own, State, Zij	Code)	
Z	~ <u></u>		Vivien Horn/S	, , ,			Wick Lan							
ē,	of Health of Health of Health of tem 27 is other tra		20a. Method of Disposition		20b. F		sition (Name of natory or other pla		Date			tion - City or To	own, State	7.7
Ë	Page nent of int if	,	1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	Linco	1n Crema	torv	11/11	/09	Brent	wood,	Maryla	ınd
Baltimore, Maryland 21215-0036	permit. Pages 1 and 20 Department of Health Important: If item 27 any injury or other trendence.		21. Signature of Funeral Service	Dicensee		10	2. Name and Address	ess of Facility	Simpl	le Trib Rockvi	ute 11e.	MD 208	352	
			23a. Part 1. Enter the disease, or shock, or hear failure. List	omplications that	caused the deat								Approximat	te tween
-	Physician		Immediate Cause Final disease or condition	()	monia								Onset and	Death
	/Medical		resulting in death) Due to (or as a consequence of):											
	Examiner	-	Sequentially list conditions,	U	static R		ell Carc	inoma						
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
~	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	CDue to	o (or as a conseq	uence of):								
8760,	icate be executed physician and the burial-transit	dical		d										
9	rtifica ng ph as th	Jed	IE EEMALE.											
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Liv	utcome of pregna e birth 2 □ Feta egnant at time of d known	al death 3	☐ Ectopic pregnan ☐ Other (specify) _	су			230	d. Date of deliv Month	-	Year
, P.O.	ires that the de signed by the a d be detached		Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause gi	iven in Part I.		23e. Did tol	oacco use	contribute to	he cause of	death?
rds	quires en sign uld be	ed by								1 □ Y€	es 2 🔼 l	No 3□ Pro	bably 4□	Unknown
of Vital Records,	The law requir te has been s age 2 should I	Completed								24a. Was a autops perfori 1 □ Yes	v	24b. Were autoprior to condeath?	impletion of	available cause of
ita	ian: rtifica ttor, p	BeC	25. Was case referred to medica	I				26. Place	of Death (0	Check only on		12100		
f V	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2] ER/Outpatie	nt 3 □ DOA Ot	her: 4 □ Nu	rsing Home	5 ⊠ Reside	ence 6	Other (Spec	fy)	
	ffe ffe	ation:	27. Manner of Death 1 X Natural 5 ☐ Pendir 2 ☐ Accident investi		te of Injury onth, Day, Year)	28b. Time o Injury	Wo	uryat ork? ∐Yes 2∐1		d. Describe ho	ow injury o	occurred		
Division	lor Atte after dez Director	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ained 200. Flat	ce of Injury - At helding, etc. (Special	ome, farm, sti	reet, factory, office		286	f. Location (Si City or Town		Number or Rui	al Route Nur	nber,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical	ng Physician: To t Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, dear ation and/or in	th occurred at the ovestigation, in my	time, date an opinion, dea	nd place, an oth occurred	d due to the d I at the time, d	ause(s) ai late and pi	nd manner as lace, and due	stated. to the cause(s)
	To th Vithir To th	Me	29b. Signature and title of certifie	er			29c. Licen	se number		2	9d. Date s	signed (Month	Day, Year)	
	10		Tho	w	/ W		D00	035859			Novem	ber 6,	2009	
	, 0		30. Name and address of person		·		·							
			Dr. Leszek Karo				Ave, 2n	d Floo	r Red	Team;	Gait	thersbu	rg, MI)
	Sta Registi		31. Date filed (Month, Day, Year)	2 2009	Registrar's Signa	B. A	barker							

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 10, 2009 Deborah Sarah Rosenblum Hirshorn November 8:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice, Casey House Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 1 F 02/04/1932 Director New York 130-26-4508 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c City Town or Location 28a-f show the Medicel Expringer must be notified at CHE 1 ☐ Yes 2 ☐ No Director Gaithersburg Maryland Montgomery the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō with items 23a 18908 Montgomery Village Avenue 20886 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 'natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: Specify: White ð 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) Montgomery County than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 Is marked other thany or other traumatic event, II w. 12 Public Schools Cafeteria Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Rosenblum Anna Ziff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrew Donald Hirshorn, son 9655 Fleetwood Court, Frederick, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State National Crematorium 11/16/2009 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 21. Signature of Full eral Service Licenses DANZANSKY-GOLDBERG MEMORIAL

MO1255 1170 Rockville Pike, Rockvil

23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition a. Pancreatic Cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a detached f ☐Yes 2 No 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Asthma Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Venous Thromboembolism page 2 s has autopsy performe certificate 1 □ Ýes 2 X No 1 □Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🖾 No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \times \bigcirc$ Other (Specify) \bigcirc Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 Pending investigation 1 🛛 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, certificate be Ö σ. Records, of Vital Physician; Division Hospital or Attending

Maryland 21215-0036

Baltimore,

Certification: ours fter death neral Director / filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours 29a, Certifier cal

(Check only one)

31. Date filed (Month

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Kouertchou

Year)

29c. License number 163748

29d. Date signed (Month, Day, Year) November 11, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jocelyn Toukep Kouatchou, MD 201 East University Pkwy, Baltimore, MD 21218

State Registrar

DHMH 17 Rev 1/2001

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2009 1:40 AM VOLLETTA JEAN HERVEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F Director 567-23-5448 Sept. 30, 1957 South Dakota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, it a Mydical Examination to confilied at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director California San Diego Poway 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 14248 Match Point Drive 92064 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2 😾 No Specify ⋧ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Elementary Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဨ Dary1 Andersen Shvonne Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14246 Match Point Dr; Poway, CA 92064 Paul Hervey / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State d 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory11/10/2009 Brentwoood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Physician disease or condition resulting in death) dymphoma 4-cars /Medical Due o (or as a consequence of): peralin Misorder Examiner ord and make Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due lo (or as a consequence o Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 □Yes 2 12 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by DISCOCT 1 Yes 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 71 by Walli certificate Atiqu 1 ☐ Yes 2 ☑ No 1 VYes 2 □No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number ahman D69478 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAHD RAHMAN 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 38809 For State Registrar AMEND#10eper FH, 11-16-09, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILBUR HEDGES, JR. Month NOVEMBER FRANCIS 1840 PM 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MARYCAND MONTGOMERY HOSPITAL WASHINGTON ADVENTIST TAKOMA PARK, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F Funeral Months Days Hours Min. May 28, 1947 226-62-8130 Washington, DC 62 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Takoma Park 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 20912 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Nidowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Gas Station Attendant Automobile Service of Health and Mental Hygie f item 27 is marked other i r other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbur Francis Hedges Betty Jean Harkins age 1 and 2 sho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Hedges/Sister 7207 Willow Avenue, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rov. 12,
George Washington Cemetery 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Sig vure Funeral Service Licensee Achard & Galey Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ONE WELK shock, or heart failure. List only one cause on each line Pneumonia Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iiniury and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 Unknown P.O. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End-Stage Renal Disease Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed Diabetes mellitus, type2 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has page 2 s autopsy performe Commany outery Disease certificate 2 🗌 No Yes 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be director, 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 Tes ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this hin 24 hours after death.

the Funeral Director. After thi

upleted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. only one) 29c. License number 7 29b. Signature and 2 MD November 9, 2009 Kenneth Khandagle, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12520 Prosperity Drive #320 Silver Spring Maryland 20904

State Registrar 31. Date filed (Month 13) Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 388IO State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 18 2009 Physician/ Andrew Holmes, Sr. 2:38 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth Month, Day, Year) Aug 14, 1946 Social Security Number 6. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Maryland 219-44-3264 63 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Keedysville 1 Tes 2 No Maryland | Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21756 U.S.A. 3522 Chestnut Grove Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Never Married 2 🕅 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Supply Co. Forklift Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian V. Toms Cleveland G. Holmes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 3522 Chestnut Grove Road Keedysville, MD 21756 Mary E. Holmes / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 11-23-2009 4 Donation 5 Other (Specify) Stauffer Crematory Frederick, Maryland Signature of Funeral Service Lidense 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1 Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and eath Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Examiner hours Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) hours MOXIC Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Vear Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 00 56379

State

Registrar
DHMH 17 Rev 7/2009

5530

Wisconsin Ave \$700

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

7

Chert

31. Date filed (Mont)

Marshall

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 38811 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11 Physician 13 2009 James William Hall, Jr. 7:55 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10845 Ocean Gateway Worcester Berlin Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6/2/1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Months Davs Hours 218-16-8166 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is and Mental Hygiene. Its marked other than "natural", or items 23a or 28a-f show raumatic event, it is Marical Examination conflict at 1 ☐ Yes 2X No Director MD Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10845 Ocean Gateway 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※ No 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify. à white 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Post Master US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones. James William Hall, Sr. Elizabeth Lange 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bill Hall son 302 Ann Dr., Berlin, MD 21811 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 11/16/2009 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** PARKIN SONISM YR5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 Z No 1 ☐ Yes 1 ☐ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 28d. Describe how injury occurred or Attending Natural 2 Accident To the Hospital or Auto-within 24 hours after death. To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 12 WORTH Registrar's Signature 31. Date filed (Month, Day, Year) 32 State NOV 17 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No.2 0 0 9 38812 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 6 Day Month 2009 **Physician** Nov. 8:32 A^{M} Agnes Gertrude Hayden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Caroline Home for Hospice Denton 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 1 F 87 Jan.23,1922 200095472 PA Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at Denton Caroline 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10e Street and Number 10f Zin Code with 21629 USA 212 Martha Jane St. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: Caucasion ğ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical @ Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 HS grad VA Hospital 12 should be filed wi h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Lewis Peterson Gertrude Agnes Mullins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 24000 Asbury Dr., Denton, MD21629 Carol L. Rouse/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/21/09 Denton, MD Denton Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Moore Funeral of Funeral Seryi Home, PA, 12 S. 2nd St. Denton, MD 21629 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, death. Immediate Cause (Final 4mos Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.0. 9 I Inknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy The certificate 2 2 No 1 □ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 10 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signa who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9, 2009 2:25 November Bijan M. Izadi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 13517 Flowerfield Drive Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/24/1943 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1**%** M 2 □ F Months Hours Iran Director 564-74-8823 66 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, the redictal Experies in multiple notified. 1 ☐ Yes 2X No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 USA 13517 Flowerfield Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2x No White Specify: Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Senior Executive Information Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Behjat Saremi-Noori ည Abolghasem M. Izadi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 13517 Flowerfield Drive, Potomac, Maryland Soudeh Mohseni S. Izadi, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 【Removal from State 4 Donation 5 Other (Specify) National Crematorium 11/13/2009 | Falls Church, Virginia 22. Name and Address of Facility
National Funeral Home Signature of Jun Licensee 7482 Lee Highway, Falls Church, Virginia 22042 MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 months disease or condition resulting in death) a Metastatic Sarcoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ∐ Yes 2 🖂 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To : After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 o. ۵. Records, of Vital Division Hospital

Baltimore, Maryland 21215-0036

To the ...
within 24 hours after
To the Funeral Dir To the

after

4 Homicide

(Check only one)

29b. Signature and title

29a. Certifier

31. Date filed (M

Medical

State Registrar

ack

and manner stated

BRUGN

completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

MID

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

12890DC

29d. Date signed (Month, Day, Year)

5410 Connecticut Avenue, NW, Washington, DC

20015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #5. For 20b, FH, TCHD, 11/24/09, r1s
106 Registrar FH, TCHD 11/13/09, pha

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death Amend 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES CLAYTON JOHNSTON Month lovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Memorio HOSDITA al aston no-If Under 1 Year If Under 24 Hrs. 8. Date of Birth ocial Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye MARCH 14, 89 Yrs. Months Days Year) 1 ▼ M 2 □ F 431-14-2245 1920 ALABAMA Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Directo 1 Yes 2 No FEDERALSBURG CAROLINE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21632 U.S.A. 101 BUENA VISTA AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates. 1964 : If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER MAINTENANCE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MANDY MILLER CHARLIE FLOYD JOHNSTON t and 2 should by the Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BUENA VISTA AVE., FEDERALSBURG, MD 21632 BARBARA DAVIS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON, VA ARLINGTON NATIONAL 21, Signature of Funeral Service Picense FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GASTROINTESTINAL HEMORRHA GE Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CARDIOMYOPATHY 19CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Yes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital s after death.

al Director: After this ce Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident 3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 00059487 Hutreine 11-12-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JAMES BOTSIS, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601 15+1 31. Date filed (Mo Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

09-09230
Donald Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

onaid Jackson		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2	009 3881
Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yea	3. Time of Death
ledical Examin		DONAL Tackson TR. Month Day Year November 27, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of	1917 hrs
		Civista Medical Center La Plata Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY Months Days Hours Min. 5. 5. 1.003	Foreign . /
Director		590-12-0956 1 Mm 2 F 3 L Yrs. S-3-19"/7	Country) Harida
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	٥	MD Charles waldorf	1 Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f sho ratic event, the Medical Examiner must be notified at once	ä		4,
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36 nin 72 l s. than "y dical B	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	WP.
5-00 ed with tygiene other	탉	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	PCDOIEGIT TO	CRSON
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturalingury or other traumatic event, the Medical Exami]٤		1D 20602
re, N I and T Health Fitem	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location	- City or Town, State
Pages nent of ant: If		1 Donation 5 Other Specific Floeward Cemetary 12-8-09 Apople	ka Flouida
Baltimore, permit. Pages Lan Department of Hea Important: If itei	- [21. Signat ré of Funeral Servic Lice ge 22. Name and Address of acility Visenta Fune (a) Home 4710 At Camp Spring (b) 200 Robert Control (c) 200 Robert Contr	Uto Place
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or he	eart Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardiovascular disease	Death
Kammer		or condition resulting in death) Due to (or as a consequence of):	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ecuted and - transi	a E	d	
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledic	MENDED 23a,27,permE, g899 1/5/10 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of	of delivery
5876 ertificat ling ph	an/N	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 2 Fetal death 3 Ectopic pregnancy Month	Day Year
Box 687 death certific he attending p	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	
that the d			tribute to the cause of death?
S, P.O uires that t n signed by	Completed by	1 Yes 2 V No 3	Probably 4 Unknown Were autopsy findings available
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seed in by the funeral director, page 2 should!			1 🗸 Yes 2 No
Vital hysician this cert	o Be	examiner? Hospital: Inserting 2 ED/Outpetient 2 DOA Other Nursing Home 5 Residence 6	Other:
ing Ph	- 1	27 Manager of Dooth 28g Date of Injury 28h Time of Injury 28g Injury at Work? 28d Describe how injury occu	rred
Sion Vittend death. ector:	catio	Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 2 Accident 1 Yes 2 No 20f Location (Street and Num	ber or Rural Route Number, City
Division ospital or Attend hours after death ineral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Num or Town, State)	bei di Rufai Rodie Ruffiber, dity
Hospital 24 hours Funeral stely filled			er as stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29b. Signature and title of certifier. 29c. License number 29d. Date signature.	gned (Month, Day, Year)
	2		r 28, 2009
3		30. Name and advess of per on who completed cause of death (Item 23a)	
ا ر		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St Regist	ate rar		
DHMH 17 Rev 1/2			
0.0145.0000		V. 1. 2. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato of Marylar	C	ertificate of	Death	Reg	. No. 2009	38816
	Physicia	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic			urgaret Lillia	n Keno			November	z 12, 2009	
	Examin	er	4a. Facility Name (If not institution, give				r Location of Deat	h	4c. County of Deat	
A. C.	Francis		Suburban Hoz	·	last birthda		thesda If Under 24 Hrs	8. Date of Birth (Month, Day, Y		gomery hplace (State or Foreign
	Funeral Director		577-22-2208	1□M 200 F 87	V	Months Davs	Hours Min.	11/21/19	21 Was	hington, DC
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location				10d. Inside City Limits
	72 hours after death with the Maryland natural", or items 23a or 28a-f show fical Evaniner must be notified at	ţō	Maryland Prince	George's		Gre	.enbelt			1 ☐ Yes 2 🛛 No
	th the or 284 e not	Directo	10e. Street and Number	000000		10f. Zip Code		10g	. Citizen of What Co	untry?
	ath wi		7 Greent				20770		u.s	
_	items items iner m	Funeral	11. Marital Status 1 ☐ Never Married 2 【X Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 🏋 No	J.S. 13	Was Decedent of F If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
5-0036	urs aff al", or Everni	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	Specify:		Specify:	Caucasian
ئ ا	72 ho natur	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Gi	cedent's Usual Occup ve kind of work done	during most of wo.		b. Kind of Business/	
[2	be filed within 72 hours after death with the Marylan ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, Ite McGeal Eveniner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life	e. DO NOT use retire Homemak	*		Own t	lame
D N	filed v Hygid other	Be Co	17. Father's Name (First, Middle, Last)		Tromanac		me (First, Middle, Ma		· one
au		To B	Allen	Powell				Rosie Go	vidner	
ary	2 shou and M is mar aumat	Γ,	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street	and Number or R	ural Route Number, C	City or Town, State, 2	Zip Code)
χ, Σ	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		Dorothy E. Kenda		4908	8 Euclid R	load, Vir	ginia Beac	ch, VA 23	3462
jore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 🛛 Burial 2 □ Cremation 3 □		cemetery, c	rematory or other pla	ce) ¦		•	
altim	# 문문를 .	3	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice			ill Cemete				Home, Inc.
ä	Depa Depa Impo any I	0 1	I Chin Kou	ve Mollo						ing, MD 20904
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not e	enter the mode of dyi	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
Y	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Ischemic	Colit	is				Onser and Death
	/Medical Examiner		Toodking in dodiny	Due to (or as a consec		Micile Co	a Pitie			
		Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec		muche co	mus			
)	acuted nd transit	Examiner	that initiated events	c. Acute Rev	ial Fa	ilure				
on,	rtificate be executed ng physician and s as the burlat-transit		resulting in death) Last	Due to (or as a consec	quence of):					
09/99	rtificate ng phys as the	Medical		d						
gox	eath cert	W/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		3 □ Ectopic pregnan	24		23d. Date of de	
	law requires that the death ce as been signed by the attend 2 should be detached or use	Physician/I	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	4 ☐ Pregnant at time of g ☐ Unknown		5 Other (specify)	-,		Month	Day Year
ŗ.	that the		Part II. Other significant conditions	contributing to death but not re	sulting in the	e underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
vital Records,	quires en sigr uld be	ed by	Hyperter	usion				1 □ Yes	2 🔀 No 3 🗆 P	robably 4 Unknown
000	law re as bee 2 sho	Completed	<u>Dementia</u>	,				24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
T	: The	E O	Gastroes	ophageal Refli	ıx Dis	ease		performe	ed? death? XINo 1 □Yes	_
7112	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		I OH	2011	ath (Check only one)		
5	Phys rrthis eral dir	٦ ا	1 Yes 2 X No 27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju	4 Li Nursing i	Home 5 Residen		ecify)
ISION	nding ath. r: Afte	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)	Injur		rki?]Yes 2 ☐ No			
<u> </u>	To the Hospital or Attending Physician: The law requires that the de within 24 buts after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		iome, farm,	street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
2	pital cons al		29a. Certifier 1 🔀 Certifying P	hysician: To the best of my kn	owledge, de	eath occurred at the t	ime date and plac	e, and due to the car	use(s) and manner a	s stated.
	e Hos 124 hr e Fun e Fun	Medical		miner: On the basis of examin and manner stated.	ation and/or	r investigation, in my	opinion, death occ	curred at the time, dat	e and place, and due	e to the cause(s)
	withir comp	Me	29b. Signature and title of contilled	Mande	1	29e: Licen	se number	290	d. Date signed (Mont	
	5			Westa	2		D53691		November	13, 2009
			30. Name and address of person who				to 110 1	2aahui PPa	Manuland	20852
	Sta	ite	Ajay Reddy, LLC 31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature		te 110, 1	werene,	mulyzunu	20032
	Registr		NOV 1 7 20	ing /2 bered	A. A	arked.				

			1- State of Maryland / State of Maryland /				lealth a Death	and M	ental Hy	giene Bea No	2009	38817
			Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	Physicia /Medic		Duk J. Kim						Novemb	er C	98, 2009	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City		Location o			40	. County of Dea	
750			Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last)	hirthday)	If Unde	l ak c	ma Pa		8 Date of Bir	th		OMELY
	Funeral Director		212-08-5246 1™ 2□ F 87	Yrs.	Months		Hours	Min	8. Date of Bir (Month, Da 1 / 2 2 / 1	y, Year, 921	C	rthplace (State or Foreign ountry) Korea
	ס		Usual Residence of Decedent						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, = ,		
	arylar show	٦c	10a. State 10b. County 10c. City, To	wn or Lo								10d. In side City Limits 1 ☐ Yes 2 ☑ No
	the M 28a-f	ect	Maryland Prince George's			DOLLE D Code	ge Pa	vrk		10a Ci	tizen of What C	
	3a or	i D	9014 Rhode Island Avenue, Apt. 8	14	101. 2	p Oodo	20740)			iblic 01	
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Dece	edent of H		nin? (Spe	cify Yes or No	_	14. Race - Am	erican Indian,
36	be filed within 72 hours after death with the Maryland ttal Hygliene. do other than "natural", or items 23a or 28a-f show event, in Modicial Event incomentation notified at	by Fu	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 👿 No		i Tes, sp i ∐Ye <i>s</i>		Specify:	, r derto r	iloari, etc.)		Black, Whi	
215-0036	hours tural"		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Sa Dooos	tent's He	al Occup	ation			16h k	(ind of Business	Asian
<u>ن</u>	filed within 72 Hygiene. other than "na ent, Ire Medic	Completed	(Specify only highest grade completed)	(Give life. L	kind of w	ork done d ise retired	during most	of workin	g	100.1	and of business	of House y
7.17.	d with giene er tha	mo(Elementary/Secondary (0-12) College (1-4or 5+)			Brok	er			Sto	ck Mark	ret - Korea
2	be file ntal Hy ad oth event	Be (17. Father's Name (First, Middle, Last)				18. Mothe		(First, Middle,			
Maryland	should be filed v nd Mental Hygie marked other I Imatic event, ID	မှ	Young Soo Kim						Gan Na			
ā Z	d 2 sh th and ?7 Is n traun				•	•					or Town, State,	21043
	s 1 an f Heal item 2 other	1	20a. Method of Disposition 20b. Place come come					·	ate	_	ocation - City or	
Ë	Pages nent or nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North					1/10	12009	Oln	ey, Mar	uland
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e- once.		21. Signature of Fureral Service Licensee 0M00 46	22	. Name a	nd Addres	s of Facility	Hin	es-Rin	aldi	Funero	l Home, Inc.
<u>n</u>	8 9 E 8 9	111	B. Key Ham, CFSI	0 11	800	New 1	Hampsi	hire	Ave.,	Sil		ing, MD 2090
			23a. Part 1. Enter the disease, or complication of that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death) a	<u>cien</u>	t							Oriset and Death
	/Medical Examiner		Due to (or as a consequence	,	Cund	t ama						11/02/2009
		ler	Sequentially list conditions, in any, leading to immediate b. Acute Coron Due to for as a consequence		Syna	rome						11/02/2009
	cuted nd ransit	Examiner	trany, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events are united by the country of	cqui	red	Pneun	onia					11/02/2009
Ď,	De exe	Ĕ	resulting in death) Last Due to (or as a consequence	e of):								
8/60,	icate be executed physician and the burial-transit	dical	d									
	certifi nding Ise as	-60	IF FEMALE: 23c. If yes, outcome of pregnancy								23d. Date of de	alivery
ž Roš	death d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1] Ectopic] Other (s	pregnancy pecify)	y				Month	Day Year
5	at the by the tache	hys	9 ☐ Unknown									
ທົ	ding Physician: The law requires that the death certifin. h. After this certificate has been signed by the attending it funeral director, page 2 should be detached for use as	[۾	Part II. Other significant conditions contributing to death but not resulting	; in the ur	nderlying	cause give	en in Part I.					to the cause of death?
cora	requir	Completed							1()	Yes 2	IXINO 3LIF	Probably 4 Unknown
ě	has t	ם							24a. Was autoj		24b. Were a prior to death?	utopsy findings available completion of cause of
_ 	n: The fficate har, pr. page		25. Was case referred to medical						1 □Yes	2 X N		s 2□No
5	Physician: r this certifica ral director, p	To Be	examiner? 1 Yes 2 X No Hospital: 1 X Inpatient 2 FR/	Outpatien		OA Othe	or:		(Check only o		6 ☐ Other (Sp	ecifu)
	ng Phy ter thi		27. Manner of Death 28a. Date of Injury 28b	Time of Injury		28c. Injur	y at		8d. Describe			cony
VISION	Attending or death.	Satio	2 Accident investigation	,=.,	М		Yes 2□N	No				
Ë	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, facto	y, office		2	8f. Location (; City or To	Street a vn, Stat	nd Number or F e)	Rural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination									
	the H hin 24 the Fi	Medical	one) and manner stated.	and/or m				ui occurre	at the time,			
	70 wit	2	29b. Signature and title of certifier	\		0c. Licens		0.1			ate signed (Mon	
	4	Y	10 Name and address of passes who completed account of the completed) (Time '	-	~(1))	414	01		_ /	1-08-	2007
			30. Name and address of person who completed cause of death (Item 23a Michelle D. Thomas, MD, PA, 1100		,	101	ano	#160	. lano	7. M	aruland	20774
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A	Lan	2		_,,,,,	, Lwigt	ا۱۲ و د	Dyrearia	
	Registra	ar	NUV 12 2009 Deneura a	J. 16	G GAR							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health a Certificate of Death	ind Menia		200	9 38818		
	Physici		Decedent's Name (First, Middle, Last) Maxine LUTZ		of Death th Mber	f ë , 2009	3. Time of Death 12:50 A м		
	/Medio Examin			4b. City, Town, or Location of Death 01 ney 4c. County of Death Montgomery					
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 93 Yrs. 6. Sex Months Days Hours		of Birth oth, Day, Y	(ear) 9.	Birthplace (State or Foreign Country)		
	aryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🌠 No		
alid 21213-0036	with the Na or 28a-1	I Direct	Maryland Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 20783			o. Citizen of What Jnited S	Country?		
	urs arrer death al", or items 2: Examiner mus	by Funeral Director	11. Marital Status 1	gin? (Specify Yes , Puerto Rican, e	or No- tc.)		merican Indian, thite, etc. white		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ita Midfrel Exeminer must be notified at ance.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of life. Do NOT use retired) Secretary	life DO NOT use retired)					
	l be filed intal Hyge ed othe event,	Be		r's Name (First, I		*			
di yi	should and Me s mark umatic	2	Fred Hyman Lillian Hirsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C						
ž ú	1 and 2 Health em 27 i		Larry Lutz, Son 4725 Cherry Valley 20a. Method of Disposition (Name of	Drive,		/ille, M			
5	Pages nent of int: If ite iry or o		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery 1			\delphi,			
Dallellor	permit. Departn Importa any inju		21. Signature of Formal Service Licensee UCICO8 TO Carroll St.,	ew Funer	al Ho	ome	20012		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause on each line.		-		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death) Se sis is Due to (or as a consequence of):						
49	ecuted and transit	e	Sequentially list conditions, if any, leading to immediate b. Pneumonia Due to (or as a consequence of):						
,		Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						
00100	tificate be executed g physician and as the burial-transit	edical E	d						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		_	23d. Date of Month	delivery Day Year		
Ų.	es that gned by be detai		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e	. Did toba		e to the cause of death?		
colds,	v requir been s should	eted	Congestive Heart Failure Cellulitis		1 ☐ Yes		Probably 4 Unknown a autopsy findings available		
ב ב	Attending Physician: The law er death. rector: Affer this certificate has by the funeral director, page 2 by	Completed	Dehydration	_	autopsy performe	prior ed? deat	to completion of cause of		
N ICO		Certification: To Be C	25. Was case referred to medical examiner? 1						
5	ing Phy After this uneral c		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day, Year) Injury Work?	28d. Des		injury occurred	эреспу)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loca	ation (Stre	et and Number o State)	r Rural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	withir Comp	Me	29b. Signature and the of certifier 29c. License number 61856		290	1. Date signed (M 11/16/C			
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Inov Mi	20	832			
	Sta		Heather Lorenzo, M.D., 18101 Prince Philip Drive, 0 31. Date filed (Month, Day, Year) NOV 17 2009 32. Jegistrar's Signature J. January	illey, I'll	. 20	002			
	Registr	ar	101 - 1 2000 JOHNMON JOI 19 GUELLE						

Registrar DHMH 17 Rev 1/2001

Division of Vital Becords P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Whe Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the total page.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown Part II. Other significant conditions	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown contributing to death but	Fetal death 3 [ime of death 5 [☐ Ectopic pregnanc ☐ Other (specify) underlying cause giv			23d. Date of deliver Month acco use contribute to the contribute of the contribute to the contribute	Day Year ne cause of death?
the death certificate y the attending physi ched for use as the t		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3		sy			
0 .0 7			Q						
Examiner sician and purial-transit	al Examiner	Sequentially list conditions, Tary, we first the properties of the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):							
Physician /Medical Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia Due to (or as a consequence of):							- 1	Approximate Interval Between Onset and Death YEALS	
permit. Departimonts any inj		21. Signature Funeral Service Brens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850							0850
7		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other plac	ce)	Date 20	Oc. Location - City or To	,
	ř	-		19b. Mailii	ng Address (Street				Code)
	Be							· ·	
	Complete	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retired	during most of work d)	ing	School Syst	
	d by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces?			dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, White, e	etc.
	al Dir				20878				try ?
	ector		ery	Gaithersk			140	Oin and Million O	1√ Yes 2 No
		216-58-8169 7/8 7/26/3					1/26/31	1 VII 10d. Inside City Limits	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)					Year) 9. Birthp Coun	lace (State or Foreign	
		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							
_							Month November	Pay Year 2009	6:47 A M
			ast)		Timodio or		2. Date of Death	g. No.	3. Time of Death
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an important: If item 27 is marked other than "natural" or items 23a or 28a-f show an important or other traumatic event; the Marieal Examiner must be refilled at once.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Examiner must be retiffied at any injury or other traumatic event, the Maryland Examiner must be retiffied at any injury or other traumatic event, the Maryland Examiner must be retiffied at any injury or other traumatic event, the Maryland Examiner must be retified at any injury or other traumatic event, the Maryland Examiner must be paged.	Physician / Medical Examiner Tuneral Director Puneral Director Funeral Director Puneral Director Funeral Selective All Mumber 1. Decedent's Name (First, Middle, Last)	1. Decedent's Name (First, Middle, Last)	Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) ALICE VIRGINIA LINCOIN 4a. Facility Name (If not institution, give street and number) Asbury Methosdist Village 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days Total Days Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) ALTCE VIRGINIA LINCOLN 4a. Facility Name (If not institution, give street and number) Asbury Methosdist Village Funeral Director Funer	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 3. Date of Death Month November 4. City, Town, or Location of Death Month November 4. City, Town, or Location of Death Gaithersburg 4. City, Town, or Location of Death Gaithersburg 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10	Decident's Name (First, Middle, Last) Decident's Name (First, Middle, Last)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ĬĨ, 2009 JANET MARIE LEHMAN November 5:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Citizen Care & Rehabilitation Ctr. Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Day, July 29, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7 Age (In vrs last hirthday) 6 Sex **Funeral** Months 1 ☐ M 2 🖫 F 212-24-6560 1929 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expension 2000. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1√Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1900 Rosemont Avenue 21702 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Smith Bertha Orem ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5808 Underwood Court, Adamstown, MD 21710 Clinton L. Lehman / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition PBurial 2 ☐ Cremation 3 ☐ Removal from State 11/13/09 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service Licenses ROBERT E. DALLEY & SON FUNERAL HOMES, P.A. NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) to allive MONITHS **Physician** /Medical Due to (or as a consequence of): **Examiner** cumaloid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2/0 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft Injury 5 Pending 1 ☐Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Chamber: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number d title of certifier 29b. Signatur 00062223

Box 68760.

P.O.

Division of Vital Records.

State Registrar

DHMH 17 Rev 1/2001

FREDELICIC, MD-21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLACE CY BOLATLUM, MD (96 TJ DLIVE,

32. Registrant Signature

LAVEEN BOLARUM, MD

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD g898 12///09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 8:30PM VOV 200 Isaak Jacob Levitas Isaak Yakovlevich Levitas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Montgomery Hebrew Home of Greater Washington Rockville Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/12/1923 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Months 1 X M 2 □ F Days Hours Russia Director 212-49-6738 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rat", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 USA 6105 Montrose Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced "natura!" Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, Its Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Higher Education Sociology Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebekka Garfinkle 2 Jacob Levitas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tatiana Levitas, daughter in law 2227 Loch Lomond Drive, Vienna, Virginia 22181 20b. Place of Disposition (Name of cametery, crematory or other place)

Garden of Remembrance 11/17/2009

Clarksburg, Maryland 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer I Service Liber see 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. MO1255 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KENAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed burial-trar resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 I Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records. JEMIA 1 Yes 2 No 3 Probably 4 Whiknown ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law page 2 s has autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To o To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number **D57284** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 16 2009 3

Registrar
DHMH 17 Rev 1/2001

State

6105

Aegistrar's Signatur

MONTROSE RD ROCKVILLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN

KORZ

Year)

ANNA K 31. Date filed (Month, Day,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22 0 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4b. City. **Examiner** 1405 0+ heson 5 Q If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗹 F Months Davs Hours Director 0448-00-710 0/10/ Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Chase Chevy montgomen 10f. Zip Code 10e. Street and Number ò "natural", or items 23a or edical Examiner must be Funeral Apt. 180 USA 5600 Wisconein Ave 21806 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced th and Mental Hygiene. ?7 is marked other than "natun traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Udell Taylor Alva Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Debra Lee/Daughter 2800 McGill Terrace, NW, Washington, DC injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 11/23/2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service. 7400 Georgia Avenue, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardiac Physician, arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 20 50 Sequentially list conditions, Examiner cause. Enter Underlying sician and burial-transit death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): anding physician are as the burial-Physician/Medical Records, P.O. Box 68760 for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown signed by the a d be detached for 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the bompleted filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical 1 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brinsfield 80

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38822 3. Time of Death 12:08 AM 2609 4ç. County of Death nonta omen 9. Birthplace (State or Foreign Country) I11. 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14 Bace - American Indian Black, White, etc. Specify: Black 16b. Kind of Business Industry Beltsville, MD 20012 Approximate Interval Between Onset and Death 30 min 40 min 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year)

BET

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0

38823

3. Time of Death

9. Birthplace (State or Foreign

MARYLAND

09

0325 M

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** LAWRENCE **JEAN** MARIE 0 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Allegan -Braddoc umberland ampus If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last 8. Date of Birth Funeral Hours 1 □ M 2 😾 F 79 Director 02/11/1930 215-26-6417 Usual Residence of Decedent 10a. State 10c. City, Town or Location show ral", or items 23a or 28a-f show by Funeral Director FORT ASHBY WV MINERAL 10e. Street and Number 10f. Zip Code RILEY'S TRAILER COURT, #20C 26719 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER UNKNOWN 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fine and Mental F HERBERT AUSTIN HAMILTON 19a. Informant's Name/Relationship (Type. Print) of Health J. THOMAS CHESHIRE / COUSIN permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 TarBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESTLAWN MEML.GARDENS 11/03/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the 15 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Lacy line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 24a. Was an autopsy After this certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pi within 24 hours after death.

-. To the Funeral Director: After the completely filled in by the funeral 27. Manual of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

10d. Inside City Limits 1 □Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry HOME 18. Mother's Name (First, Middle, Maiden Surname) MILDRED VIRGINIA CHESHIRE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 McKINLEY STREET, WESTERNPORT, MD 21562 20c. Location - City or Town, State LAVALE, MD UPCHURCH FUNERAL HOME, P.A. 202 GRFFNF STREET, CUMBERLAND, MD Approximate Interval Between Onset and Death DDEN 23d Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, 32. Registrar's Signature

State Registrar

09-08921						
Penny Lewis						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 38824 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 16, 2009 **Medical Examiner** 2259 hrs Penny Lynn LEWIS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 4936 Porterstown Road Keedysville Washington 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Months Days Hours July 11 1962 Director 212-84-2467 м 2X F 47 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f shov notified at once, Maryland Washington Keedysville 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 4936 Porterstown Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White δ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Aid Nursing Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lewis <u>Linda</u> C Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Socks - Aunt <u>12120 Heather Drive,</u> Hagerstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, Burial 2 X Cremation 3 crematory or other place) Removal from State 11/20/09 Hagerstown Crematory Hagerstown, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd, Hagerstown, Md 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac arrhythmia associated with left ventricular Physician Between Onset and /Medical dilatation and fluoxentine and amitriptyline use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 3a, PII, 27, permE, g902 4/13/10 TT the attending physician ed for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ σ. Yes 2 No 3 Probably 4 ✔ Unknown Seizure disorder; obesity Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed? Yes 2 No 1 🗸 Yes 2 Nο 25. Was case referred to medical 26.Place of Death (Check only one) Vital Be examiner? Hospital: 1 Other 4 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 this 1 V Yes ð After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Certification: Division 1 X Natural Director: Yes 2 No Pending 24 hours after death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 17, 2009 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Carol Allan, MD

31. Date filed (Month Pay

111 Penn Street, Baltimore, MD 21201

32. Registrar's Signature

Assistant Medical Examiner

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/13/2009 Year Physician/ 22:07 pm Hazel Darcey Lunsford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Center Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 □ M 2 🛭 F Min. Months Days Hours 0171771930 Washington, DC 79 Director 579-36-4306 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Forestville MDPrince Georges 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? è Funeral items 23a U.S.A. 20747 2600 Ritchie Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No 9 δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 ☐ Divorced Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 is and Mental Hygiene.
77 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Substitute Teacher 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mabel Day John W. Darcey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 44581 Bellview Ct., Tall Timbers, MD 20690 19a. Informant's Name/Relationship (Type, Print) Marilyn Cox/Daughter f Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/19/2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) of Juneral Service L 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 Mount 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No 25. Was case referred to medical examiner?

1 Ves 2 No eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Inpatient 2 ER/Outpatient 3 I DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injun 1 Accider 5 Pending 113109 death. 22 47 PMM 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Sumber of Bural Route Number City or Town, State) 4 Homicide determined hours after rastvilla home within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 18 2009 Year Lee 10:00 A Beulah Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington Ft. Washington Rehabilitation Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours May 10. 1908 South Carolina 247-52-2613 101 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f shor Examiner must be notified at Director Prince George's Suitland 1 Yes 2XX No Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5008 Silver Hill Road 20746 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: "natural", Black Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Seconday (0-12) uth and Mental Hygiene.
27 is marked other than r traumatic event, the M. College (1-4 or 5+) Self - Employed Housekeeper Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 0 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl J. Lee / Son 5008 Silver Hill Road Suitland, Maryland 20746 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Emmauel AME Church Cem 11/20/2009 Charleston, S.C. 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility ^{2. Name and Address of Facility} George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 alas . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Day Month Year Pregnant at time of death Yes X2 X No ate has been signed by the apage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 2 X X Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2X XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Could not be

Division of Vital Records, P.O. Box 68760

after death.

Director: After this certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Certificate: To 2 Accident
3 Suicide 4 Homicide Medical 29a. Certifier (Check

29b. Signature and title of certifier Ald

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa, M.D. 7700 Old Branch Ave. Clinton, MD. 20735

Certifying Nurse Practioner: To the best of my knowledge, dea

determined

31. Date filed (Month, Day, Yea, NOV 1 9 2009

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

State

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 1 12/4 Degrificate of Death per Dr. g898 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 1500PM Gir1 eptember 29 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days 1 □ M 2 K F Hours Min. Infont Director September 29 10 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heathh and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Maxical Examinal in that be notified at Yes 2 No Maryland 10e. Street and Number Director Baltimore 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. States Avenue United 21217 Newingtor Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify <u>Ş</u> If Yes. Give Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN Jashau ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Baltimore, Haryland Sashay Lyle / Mother 739 Newington 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 212 Date Burial 2 Cremation 3 Removal from State Certhedral 7,2000 Boultimore, Hary land 4 ☐ Donation 5 ☐ Other (Specify) May AVENUEN 21. Signature of Funeral Service Licensee 22. Name and Addres of Facility BALTIMORE, er De advoir Long Susan Lyn MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prematuriti Extreme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? cate has by page 2 si 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 1 □ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Coton

Avenue

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

Registrar's Signature

Raymond Cox

31. Date filed (Month, Day, Year)

DEC 0 4

October 1 2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38828 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** NANCY MUTTER NOVEMBER 10 2009 6:40 A WINTJEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7437 TIMOTHYS WAY TALBOT EASTON 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 75 AUGUST 14,1934 NEW YORK Director 065-28-1861 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Madical Examinar must be notified at 1 ☐ Yes 2X No Director MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7437 TIMOTHYS WAY 21601 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 📉 No WHITE Specify: Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION TRANSPORTATION CONSULTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM WINTJEN MARION CASSON ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINALD MUTTER/HUSBAND 7437 TIMOTHYS WAY, EASTON, MD 21601 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 11/13/2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euseral Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD by one cause on each line. Approxima e Interval Between Onset and Death 23a Part Enter the disease, or construction shock, or heart failure. List only Immediate Cause (Final **Physician** letasta disease or condition resulting in death) Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l page 2 s autopsy The certificate of Vital 1 ☐ Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 X Natural is 24 hours after death, in Funeral Director: Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 DESHIELDS, MD MARY S. 401 PURDY STREET, SUITE 101, EASTON, MD 21601 31. Date filed (Month 32. Registrar's Signature State Year) 1 2 2009 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Meghan Thompson McAneny Month Da November Year 2009 6:40 am 15, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2312 East Gate Drive Montgomery Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Sept. 16, 1 □ M 2 🕶 F Months Days Min. 197 Washington,DC 219-04-4423 32 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 20906 USA 2312 East Gate Drive 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc 1X Never Married 2 ☐ Married ğ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. uld be filed within 7. I Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laurence Raymond McAneny, II Mary Faye Thompson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 i Laurence R. McAneny, II/Father 2312 East Gate Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any Injury or ot ^N0 2009 1 Durial 2 Cremation 3 Removal from State 18, Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring. 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that as d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pitysician disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to Exam certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last bunial-1 attending physician for use as the bunal Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ The law requires that the death in the past 12 moons? 1 Yes 2 No Month Year Pregnant at time of death 9 Unknown the 9 Unknown P.O. I þ signed t Part II. Other significant conditions sulfing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to calca 26. Place of Death (Check only one) Be examiner? 1 \(\text{Yes} Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 2 29b. Signature e of certifier

State

Registrar

Penny Bisk, MD

2009

Registrar's Signature

ted cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue, #301, Silver Spring, MD 20902

			For State Registrar		S	tate of M	arylan			ent of F ate of	Health and I	Mental H	ygiene Reg. No	0 0 0	38830			
		_	1. Decedent's Nam	ne (First, Middl	e, Last)							2. Date of D		2000	3. Time of Death			
	Physici		Molouk			oghadam						Month Novemb	Day		3:55 aM			
and and	/Medio Examir		4a. Facility Name (4b. C	City, Town, o	r Location of Death			County of Death				
-	_xuiiii		804 Aml		_					Gaith	nersburg			Monte	gomery			
	Funeral	Г	5. Social Security N		6. Sex	7. Ag		last birthda	y) If Ur Mon	nder 1 Year		8. Date of B	irth		nplace (State or Foreig			
	Director		219-13-13 Usual Residence of		1 🗆 M	2 A F	83	Yrs.	IVIOTI	Days	riours IVIIII.	8. Date of B (Month, L March	23,	1926 Î	ran			
	/land		10a. State	10b. County			10c. Cit	ty, Town or	Location						10d. Inside City Limit			
	Mar a-f st	ż	Maryland	Montg	omery		Ga	ither	sbur	g					1 ∐Yes 2 🔀 No			
	h the	ji e	10e. Street and Nu	mber					10f.	Zip Code	-	-	10g. Cit	izen of What Cou	intry?			
	23a c	je.	804 Amb	er Tree	Cour	t #204				208	78		Uni	ted Stat	tes			
	ems	Funeral Director	11. Marital Status		12.	Was Decedent Armed Forces?	Ever in U.	.S. 1:	3. Was Do	ecedent of h	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N	10-	14. Race - Amer Black, White				
36	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Modical Exercines rout by a culfied at		1 Never Mari		ied 1	l ∐Yes 2 🔀 l fYes, Give	No			s 2X No	Specify:	,		Specify: Wh:				
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on	Attending Firdeath. ector: After by the funera	ig	1 X Natural 2 ☐ Accident	5 Pendir		(Month, Da	ıy, Year)	Injur	y M	Wor	rkí?]Yes 2.∐No			•				
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	e Hospital or 124 hours afte e Funeral Dire letely filled in B	Medical C	29a. Certifier (Check only one)		Examiner:		of examina				ime, date and place opinion, death occu							
	To the within 2. To the I complet	Me	29b. Signature and	d title of certifie)				29c. Licens	se number		29d. Da	ite signed (Month	n, Day, Year)			

State

Victor M. Priego, M.D.

6420 Rockledge Dr., Suite 4100; Bethesda, MD 20817 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D23308

November 12, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38831 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Micale Jean Capinelli LOVEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country). Funeral 209-07-9893 Days Hours Jan. Tay, Year 913 96 **Director** Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Co. Boonsboro 1 🗆 Yes 2🏝 No 10e. Street and Number 10f. Zip Code 21713 10g. Citizen of What Country? Funeral 19504 Roxbury Road U.S.A. within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2XX No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3XXWidowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thomas Capinelli Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Micale / Son 19504 Roxbury Road, Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Smithsburg Crematory Nov. 19,2009 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home N. Hagerstown, MD 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ EVERE AORTIC STENOSIS disease or condition resulting in death) Medical **Examiner** CARDIOMYOPA74 Sequentially list conditions. Examine Due to (or as a consequence oi). if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury CONGETTIVE Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year i signed by the a q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 5 Pending (Month, Day, Year) 1 X Natural within 24 hours after death. To the Funeral Director: A Accident 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number MOHAMMED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-0

MUNKMMED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Raymond Lee McKenzie 3:25P M NOVEMBER 2009 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Washington Reeders Memorial Home Boonsboro 8. Date of Birth (Month, Day, Year)
June 26, 1952 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours Min 1 T3 M 2 □ F 212-58-9893 57 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 KINo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16608 Coney Court 21795 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: If Yes, Give Army Nat Year or Dates: Guard Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 manufacturing mechanical assembly 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleora June Glover William Taylor McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16608 Coney Court, Williamsport, Md. 21795 Sylvia McKenzie - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstewn Crematory 11/18/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Euneral Service Lig 415 E.Wilson Blvd., Hagerstown, Md. 21740 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest art 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Monia Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

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certificate !

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To the Hospital or Attendential within 24 hours after death To the Funeral Director:

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P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

permit. Pages 1 and 3 Department of Health important: if Item 27 any injury or other tra

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Physician

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Examiner

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wolfost Examiner must by notified at

filed within 72 hours after

1 and 2 should be 1 Health and Mental

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Sequentially list conditions

dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last
Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □Yes 2 □No 9 □ Unknown
0	Part II Other planificant or

examiner' 1 Tes 2 No

28a. Date of Injury (Month, Day, Year) 28b Time of

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certif

106323

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

580 NORTHERN AVENUE, HAGERSTOWN, MARYLAND 21742 301-733-4496 SHAHID MAHMOOD, 31. Date filed (Month, Day, Year) 32.

54-4+1 State Registrar

NOV 19



State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2 0 0 9 38833 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18 2009 Irma Rosella Mvers November 5:40 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Williamsport Nursing Home Williamsport Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours 214-09-4244 Director Aug. 3,1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanting must be notified at aging. 10a State 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 □ No Funeral Director Maryland Washington County Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 N. Artizan St. 21795 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ≥ Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Lushbaugh, Sr. Viola L. Mowen Lushbaugh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David K. Myers-son 13203 Hillendale Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 11-21-2009 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each dise. Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) AND /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by SCLEROSIS MULTIPLE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation ieral Director: A 1 ☐ Yes 2 No 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) November, 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-L , WILLIAMSPORT. 154 N. ARTIZAN ST ED 31. Date filed (Month, Day, Year 32. Registrar's Signature State NOV 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38834 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Hmmolu Manidadapu 12:01 PM November 24 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sount Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Min. Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2/30 F Director intant Maryland Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Eraminer must be putified at 1 □ Yes 🎾 No Director Mary land 10e. Street and Number Howard olumbia 10g. Citizen of What Country? Turnabout Lane Apartment 9 6109 21044 ndia by Funeral 2 should be filed within 72 hours after death is and Mental Hygiene.

is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE Enfant NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evones. Burnachandra Mandadapu Machavarapu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) one Apartment 9 Columbia Burnachandra Mandadapu/Father 6109 Turnaboat 1 May 7,2010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetary 21044 22. Name and Address of Facility SHINT 21. Signature of Funeral Service Licensee HOSP HON GOOS. BALTI CATION AVEN MARY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respirator Failure /Medical Due to (or as a consequence of): Examiner ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). certificate be executed attending physician and for use as the burial-transit Exami txtreme Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ξ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 🟋 No 2 🗆 No 1 ☐Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely 29b. Signature and title or certifier 29d. Date signed (Month, Day, Year) 29c. License number D14955 November 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue Agnes Hospital Baltimore, Maryland Registrar / Signa Santos

State Registrar Arturo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November :50 AM 2005 Robert Francis Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Friendship 264 Friendship Road Anne Arundel If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth g. Birthplace (State or Foreign 09-12-1930 1 X M 2 - F Days Hours New Jersey Director 130-20-8324 79 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 264 Friendship Road 20758 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, 1 X Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Year or Dates.1948-52 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Secretary of Education Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis Joseph Miller Dolores Elizabeth O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanche Dunaway Miller, wife Friendship Road, Friendship, MD 20758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Our Lady of Sorrows 11-21-2009 West River, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after cleath.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 si autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 😿 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 15+1 Marme and address of person unap. MO 2140 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

NOV

			1 - State Registrar	State of Marylar		rtificate of			g. No.	19	388	3 b
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day	Year	3. Time of Do	
1	/Medic	al	Paul Leroy Nur	namaker		Ab City Town o	r Location of Death	November	20, 2		2:00	Рм
7	Examin	er	Julia Manor Heal		r	Hagerst				hingt	on	
	Funeral Director		5. Social Security Number 6. S 220–18–0723		. last birthday)			8. Date of Birth (Month, Day, July 4,		9. Birthp	lace (State or F Tand	-oreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside City	Limits
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	th the	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of V	Vhat Coun	ntry?	
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21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "naturel, or iteme 23a or 28a-f ehow event, the Medical Exam har must be notified at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in t Amed Forces? 1 (X)Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		e - Americ ck, White, '' Whi	etc.	
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an	should be filed wil nd Mental Hygien marked other thi matic event, the	To Be	Karl Pry Nu	ınamaker			Alda	Kelly				
, Maryland	nd 2 s lith ar 27 le r trau		19a. Informant's Name/Relationship (Gary L. Nunamaker	/ Son	4914	Harpers	and Number or Rura Ferry Roa	d Sharp	sburg,	Mary	yland	217
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispe cemetery, cre	osition (Name of matory or other place	ce)	ate	20c. Location -	City or To	own, State	
ţim	Depermit. Page Depertment of Importent: If Inny Injury or DICE.		4 □Donation 5 □ Other (Specific) Be		Cemetery					aryland	
Bal	permit. I Depertm Importer any Injure once.	,	21. Signature of Foreral Service Ucer	1 NOO			^{ess of Facility} Bas National P				Home, 21713	
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7	/Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):	2 1/00	201 141	7) (10	- 00			
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.O. Box	death cer e attendir id for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у			te of delive onth	ery Day Ye	ar
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Division	or Attendatter death Director: in by the	fica	3 Suicide 6 Could not b	e 28e. Place of Injury - At I	home, farm, st			28f. Location (St	reet and Numb	oer or Rura	al Route Numbe	ar,
Ö	s after s after al Dire	Certification:	4 Homiside	building, etc. (Spec	city)			City or Towr	n, State)			
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Greck only one) (Greck only one)	nysicien: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, dea nation and/or in	th occurred at the tinvestigation, in my t	me, date and place, opinion, death occurr	and due to the ca ed at the time, d	ause(s) and mate and place,	anner as s and due to	tated. o the cause(s)	
	Mith To t	2	29b. Signature and title of certifier	WMD		29c. Licens	8245837	2	9d. Date signe	d (Month,	Day, Year)	•
5	H 5+1		30. Name and address of person who SUA B 31. Date filed (Month, Day, Year)	8100-00	4 3	Print)	Julia	tam	Avec	ie 4	ap Mt	217
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38837 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pa 20 2005 Barbara Karen Noll 4:25 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Pennsylvania Director 168-28-9853 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Franklin Greencastle 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15159 Mercersburg Rd. 17225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Custom Drapery Salesperson Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nathan Carnig Pearl Levine Carnig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Noll-husband 15159 Mercersburg Rd. Greencastle, PA 17725 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 11-24-2009 4 Donation 5 Other (Specify) Cedar Lawn Mem Park Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition Opset and Death Physician month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performe After this certificate 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work Accident 1 Yes 2 No Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one 29b. Signatu 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

e and address of person who completed cause of death (Item 23a) (Type, Print)

32

Registrar's Signature

th, Day, Year) NOV 2 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI 1ine a-5, 285 e &f per ME 8898 12/17/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38838 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2009 5:05 PM IMOU Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min. 052-22-8293 New York Director 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director Constableville Lewis County New York 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13325 U.S.A. 3970 Mackey Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 1946If Yes, Give 1946Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Highway Department Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Herman Ortlieb Lily Closs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4931 Highmarket Rd. Constableville, NY 13325 Diane Cavanaugh-daughter 20b. Place of Disposition (Name of Stephen Ste 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-25-2009 Croghan, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home .331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as condiac or respiratory arrest shock, or heart failure. List only one cause a each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 signed by the attending p d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day 2 No 9 Unknown 9 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28b. Time of injury **6:29** 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be jury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Boute Num City or Town, State) L—81 at South d. State Line, PA determined Young Rd. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c/ License number 2 cause of death (Item 23a) (Type, Print) Dr - Mark 30. Name and address of person who complete Hagerstown MD 21740 31. Date filed (Month, Day, Year 32. Registrar's Signature NOV 2 Registrar

09-08104 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be Cor	17. Father's Name (First, Middle, Last) Maxwell Ob					He1	en Ma	urer	den Surname)			
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Division of Vital Records, pital or Attending Physician: The law require ours after death. After this certificate has been siffled in by the funeral director, page 2 should be	ertification:	3 Suicide 6 Could not be 28e. Pl	ace of Injury - At home, farm		t, factory, o	fice buil	lding, etc.	or	Town, Sta	reet and Number or te) Ave., College Pa			7
2 E = >	Medical C	29a. Certifier (Check only one) Certifying Physician: To the to the control one) Wedical Examiner: On the bas	is of examination and/or inv	occurr estigati	ed at the tir on, in my o	ne, date oinion, d	and place, death occurr	and due to red at the tir	the cause(ne, date ar	s) and manner as s	stated. o the ca	use(s)	
To To	₩ W	29b. Signature and title of certifier	a stateu.			icense r			- 1	29d. Date signed (Day, Year)	7
	-	Famule Prushed Vo 30. Name and address of person who completed or	ause of death (Item 23a)		(D.C.M.	.E.			October 19, 2	J09 ———		-
		Pamela E. Southall, MD Assistar	nt Medical Examiner			treet,	Baltimor	e, MD 21	201				
Sta Registi	ite ar	31. Date filed (Moorts Pay 198 2009 32)	Registrar's Signatus	bau	مري								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7, 8:20 P.M 2009 November Perez Luis Angel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery Birthplace (State or Foreign Country) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Funeral Min. Months Days Hours 1 X M 2 □ F Jan. 18,2007 Director 217-77-7571 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Director Maryland | Montgomery Germantown 10c. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20022 Appledowre Circle 20876 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Mexican Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 0 None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Argelia Perez Rosendo Perez ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Argelia Perez/Mother 20022 Appledowre Circle, Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 11/12/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home O East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician 5 days Influenza HlN1 disease or condition resulting in death) /Medical Examiner Neurodegenerative Disease of Unknown Etiology 2½ years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of r. Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the ! use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed page 2 X No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 K Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury 1 XNatural 5 Pending To the river after death.

within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ò 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier MD D 65967 November 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Liliana Simon, M.D., 31. Date filed (Month) Year) 32. Registrar's Signature State Registrar

OH-2 State

Steven Blash MD 31. Date filed (Month, Day, Year)

324 E. Antistamst. Suits 32. Registrar's Signature

NOV 24

Registrar

Hageistown

21140

			State of Maryland / Dep		Mental Hygiene									
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. No. 2 0 9	, 38842 1								
	Physicia		Lula Mae Peterson		November Day 15, 2009	3. Time of Death 9 10:20 aM								
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	1								
			Holy Cross Hospital	Silver Spring	Mont	gomery								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 日本 2 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birth (Month, Day, Year) Cou	hplace (State or Foreign intry)								
	Director		238-40-8418 79 Yrs. Usual Residence of Decedent		Oct. 10, 1930 Nor	th Carolina								
	and show	or	10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits								
	Mary 28a-f otifie	Director	N.C. Hyde Swar	Quarter		1 ☐ Yes 2 🖾 No								
	h the	al D	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?								
	ms 2; must	Funeral	195 Juniper Bay Road	27885	USA									
(0	or ite	by Fi	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒️ ♣o	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.) 14. Race - Amer Black, White									
ĕ	ırsaft ıral ", IExal	edk	3 🕱 Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:	Specify: B1	.ack								
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ر م	Hygiw other ent, t	Be (17. Father's Name (First, Middle, Last)	ustodian 18. Mother's Nam	ne (First, Middle, Maiden Surname)	-								
<u>lan</u>	d be fi dental rrked tic ev	욘	Arthur L. McCullor	•	Lee Benson									
Maryland 21215-0036	shoulk and h is me auma		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Rur	al Route Number, City or Town, State, Zip	Code)								
€,	and 2 lealth em 27 her tr				Silver Spring, MD 2									
Baltimore,	ge 1 and the of the or of		TE Bandi E E Grandatori o Es ricinovarioni otata	ematory or other place) NOV	Dat 18, 20c. Location - City or									
ij.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 - Bondaon o - Other (Option)	1	OO9 Swan Quart									
Ba	Dep Imp any		Eru & Scerlo	Francis J. Collin: 500 University Bl	s Funeral Home Inc. vd. W., Silver Spri	ng, MD 20901								
			23a. Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between								
- 3	Inysician/	Ž 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Sepsis											
) Medical Examiner		resulting in death) Due to (or as a consequence of):											
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6	ansit	Examiner	cause. Enter Underlying Cause (Disease or imijury											
	exectian an	EX	that initiated events resulting in death) Last Due to (or as a consequence of):											
9	death certificate be executed he attending physician and ed for use as the burial-transit	dical	d											
Box 687	eath certifica attending ph for use as th	Physician/Me	IF FEMALE: 23b Was decedent program 23c. If yes, outcome of pregnancy											
ŏ	atten atten for us	ciar	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of deli Month	very Day Year								
B	es that the des signed by the a be detached	hysi	g ☐ Unknown											
P. O.	that gned to	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?								
ds,	quires en siç ould b	ted	Hypertension, Leukemia		1 Yes 2 No 3 Pr	obably 4 🖰 Unknown								
Ö	law re las be	Completed			autopsy prior to c	opsy findings available ompletion of cause of								
æ	The icate l				performed? death? 1 Yes 2 No 1 Yes	2 🗆 No								
ita	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Chec		- Y								
d	g Phy er this eral d	e: To	27. Manner of Death 28a Date of injury 28b Time	of 28c. Injury at	ome 5 Residence 6 Other (Speci 28d. Describe how injury occurred	fy)								
O	endin eath. or: Aft he fun	ficat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No										
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number or Run City or Town, State)	al Route Number,								
Ξ	pital ours a ceral D		29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death	occured at the time, date and place of	ad due to the source(a) and manner as ato	tod								
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invo	stigation, in my opinion, death occurred a	it the time, date and place, and due to the c	ause(s) and manner stated.								
	To the within company		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month	, Day, Year)								
	7		- growie &Meur	D56691	November 1	5, 2009								
_			30. Name and address of person who completed cause of death (terr 233) (Type Ghousia Sultana, MD 1500 Fores		er Spring, MD 20910									
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature											
	Registra	ir	NOV 18 2009 Server A. Ja	wed .										

			For State Registrar		Sta	ite of M	larylan		artmei <i>rtifica</i>				ental Hy	gien	200	9	388	44
			negistrar Decedent's Nam	ne (First, Middle	e, Last)								2. Date of De	eath			3. Time of	
	Physici		Lillia	n Rosen	field								Month Novemb	Da ner (/ear) ()	2:25	A M
	/Medio		4a. Facility Name (and number)		4b. City	, Town, or	r Location	of Death	TIO V CILLO		. County of		2.25	
1	?		Suburba	n Hospi	tal					these				1	Montgo			
	Funeral		5. Social Security N	Number	6. Sex 1 ☐ M 2			last birthday) If Unde Months	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)	9. Birthp	place (State of atry)	or Foreign
	Director		578-01-3				9	6Yrs.					04/28	/191	.3 N	lash:	ington	DC.
	land ow		10a. State	10b. County			10c. Cit	y, Town or L	ocation							1	0d. Inside Ci	ty Limits
	the Maryland 28a-f show	ģ	MD	Monto	am a 1611		D	ethesc	ام								1 X️Yes	2 □ No
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		Funeral	11. Marital Status		12. Wa	as Decedent		S. 13.				rigin? (Spe an, Puerto F	cify Yes or No Rican, etc.)		14. Race	- Americ		
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ö	72 hours after "natural", or ite	d be	3X Widowed			ar or Dates:		162 Door	edent's Us	al Occup	ation			16h H	Kind of Busi	Whi		
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12	within jiene. r than	l wo	Elementary/Seco	ondary (0-12)	Co	llege (1-4or	5+)		sines					G:	rocer	y Re	tail	
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<u>a</u>	uld be Aental rked c	TO E	Louis B	erman							Mar	v Baur	mgarte	n				
Maryland 21215-0036	should and Mer s marke	-	19a. Informant's N		nip <i>(Type. Pr</i>	int)		19b. Mail	ing Addres	s (Street		-	l Route Numb		or Town, S	tate, Zip	Code)	
Σ	and 2 ealth a n 27 is		Roberta	Sands /	Daugh	ter							ckvill					
Baltimore,	permit. Pages 1 and 2 should be i Department of Heath and Mental Important: If item 27 is marked o any Injury or other traumatic eve once.		20a. Method of Dis	sposition Cremation	3 □ Bemov	al from State	20b. F	Place of Disp emetery, cre	osition (Na matory or	ame of other plac	ce)	Da	ate	20c. L	ocation - C	ity or To	wn, State	
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Salt	permit. Departr Importa any Inji		21. Signature of Fu	uneral Service	Licensee				2. Name a	ınd Addre	ss of Faci	lity Danz	zansky-	-gol	dberg	Mem	orial	Chap1
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				art failure. List	complication only one cau	s that cause se on each l	d the deatl line.	h. Do not er	nter the mo	de of dyir	ng, such a	as cardiac o	r respiratory a	arrest,			Approximat Interval Bet Onset and	ween
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o x	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If y	ves, outcome ☐Live birth	e of pregna	ancy I death 3	☐ Ectopic	pregnanc	:v				23d. Date		•	V
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LI Man 11-	sician; The law s certificate has b irector, page 2 sl												1 □Yes	ormed? 2 X N		ath? □Yes	2 🗆 No	
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75	ding h. After funer	ig Ei	1 X Natural	5 Pending		a. Date of Inj (Month, D	ay, Year)	Injury	M	28c. Injur Wor	k? Yes 2[Lou. Describe	now mje	ary occurre	u		
<u> </u>	Atten deatl ctor: y the	fica	2 ☐ Accident 3 ☐ Suicide	6 Could r	ot bo	e. Place of In	njury - At ho	ome, farm, s					28f. Location	(Street a	and Numbe	r or Rura	al Route Nun	nber,
2	after Dire d in b	Certification: To	4 Homicide	determ	inea	building, e	etc. '(Specif	ome, farm, s fy)		,,			City or To	wn, Sta	te)			
35	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ical C	29a. Certifier (Check only	1X Certifyin 2 Medicai	Examiner: C	n the basis	of examina	owledge, dea	th occurre	d at the ti	me, date	and place, a	and due to the	e cause e, date a	(s) and mar	nner as s	stated. o the cause(s	s)
Z	thin 2 the l	Medical	one) 29b. Signature and	title of cortific		nd manner s	tated.		20	Oc Licens	se number	r	1	29d D	ate signed	(Month	Day, Year)	
	5 × 5 × 0		25D. Signature and	1. /.	-	WI	00 -	10	2	AAI	(-/	7-	>	11	141	19	_, . 501)	
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	Registr			NUV 1	2009	Den	un	d.	back									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 3:47 a M Viola Maria Rinaldi November 10, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Hours Months Days 1 □ M 2 🔀 F 94^{Yrs.} Feb. 28, 1915 Washington, DC Director 577-07-9513 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ir e l'edical Examiner must be notified at 1XX es 2 □ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3500 International Drive 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes **XX**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) iene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, Irai. once. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Totaro Josephine Sturiale ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laura N. Rinaldi/Granddaughter 3021 11th Street, NW, Washington, DC 20001 Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 14, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 1000 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown signed by t I be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s performed? certificate 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 ₩ Natural 2 Accident 5 ☐ Pending investigation n 24 hours after death.

ne Funeral Director: Aft
pletely filled in by the fur 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Koueltchou ND Vember 11,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD 1355 Piccard Drive, Rockville, MD 20850 NOV 1 31. Date filed (Month) State Registrar

1- State Registrar Amended#26perMD FCHD KS 11/Dentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 27, 2009 **Physician** 6:10 A M CHARLOTTE ANN KEDDICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick

9. Birthplace (State or Foreign Country) Mount Airy, Maryland Kline Hospice House 8. Date of Birth (Month, Day, Year 8–25–1936 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 73 Yrs Maryland 215-50-9369 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" -- " any injury or other traumatic events." 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Maryland Frederick Thurmont 1 ☐ Yes 2 → No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13841B Pryor Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Celius W. Reddick Lula Irene Crum ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Hauver Sister 13841B Pryor Rd. Thurmont, Md. 21788 20c. Location - City or Town, State 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel Cemetery 10-29-2009 Frederick Co. Md. ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused he shock, or heart failure. List only one cause on each line.// death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** BLOCK LOSS ANEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CANCER UTERINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed VALVULAR HEART DISEASE resulting in death) Last Due to (or as a consequence of): PULMONAMI HIPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) NIA-9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 ☐Yes 2 DNO 1 ☐ Yes 2 10 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Acidence 6 Other (Specify) No. 1111 House line 1 Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0070 BER 28, 2009 -MO029636E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 S.WASHINGTINST; GETTY SSURB PA 17325 524 MICHAEL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2009 Deneva Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registr <i>a</i> r	State o	of Maryla		artment ertificate		ealth and N		giene Reg. No.	2000	2001.7
Physicia	an	1. Decedent's Name (First, Midd	_{le, Last)} aren Marie	RIDEN			0. 2		2. Date of De Month Novemb	ath	Year	
/Medic Examin		4a. Facility Name (If not institution 10117 Downsvill	on, give street and nu					ocation of Death	Novemb	4c.	County of Dec	ath
Funeral Director		5. Social Security Number 213–82–4093	6. Sex 1 ☐ M 2X F	7. Age (In yı	s. last birthday) If Under 1	_	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da January	rth ay, <i>Year)</i> y 1, 1	.961 9. B	irthplace (State or Foreign Country) Lary Land
ne Maryland 8a-f show	Director		ington		City, Town or L	√n						10d. Inside City Limits 1 ☐ Yes 2 No
th with th 23a or 2 ast be no	ral Dire	10e. Street and Number 10117 Downsvill	le Pike			10f. Zip C 21	740			-	zen of What C	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a fination is a notified a once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 🖾 Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Formed Tried 1 Tes	2 ⊠No ive	U.S. 13.	Was Deceder If Yes, specify 1 ☐ Yes 2		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Black, Wh	nerican Indian, ite, etc. white
within 72 ho jene. r than "natur	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12) 1 2	nt's Education est grade completed) College (1-4or 5+)	(Giv		done du retired)	tion uring most of work assistan			of Busines	s/Industry
ld be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle Berna	Ard Alvin	Keatin	g			18. Mother's Nam				ivengood
nd 2 shou alth and N 27 is mar r traumat	_	19a. Informant's Name/Relation Brian Ridenou:		ıd	19b. Mail	ing Address (S	Street a	nd Number or Rui	al Route Numb , Hager	er, City o	r Town, State n, Mar	, Zip Code) yland 21740
Pages 1 a ment of Her ant: If item jury or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State	Place of Disp cemetery, cre Rose Hi			Novem	nber 5,2009			or Town, State
permit. Depart Import any inj once.		21. Signature of Funeral Service	Licensee			22. Name and L5 East		•	Minnic d., Hag			Home aryland 21740
Physician /Medical		23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on	each line.	Car	nter the mode	of dying	, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Examiner	Į.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a cons								
rate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	(or as a cons								
	ledical		d									
Attending Physician: The law requires that the death certific r death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		birth 2 🗆 Fo gnant at time o	etal death 3	☐ Ectopic pre ☐ Other (spe					23d. Date of c Month	delivery Day Year
uires that the de n signed by the a Id be detached fi	þ	Part II. Other significant condit	ions contributing to c	leath but not r	esulting in the	underlying cau	use giver	n in Part I.				to the cause of death? Probably 4 Unknown
The law requir ate has been si page 2 should l	Completed						-		24a. Was auto perfo 1 □ Yes		prior to death	autopsy findings available o completion of cause of ?es 2 \(\sum \) No
sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hoenital:		☐ ER/Outpati	2 DOA	_	26. Place of Deat			0	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To	27. Manner of Death Natural 5 ☐ Pendi	28a. Date		28b. Time		c. Injury Work?		28d. Describe		6 ☐ Other (S) y occurred	респу)
al or Atte s after de: al Directo ed in by th	Certific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be mined 28e. Plac build	e of Injury - At ling, etc. <i>(Spe</i>	home, farm, s	treet, factory, o	office			(Street an wn, State		Rural Route Number,
he Hospit in 24 hour he Funera pletely fille	Medical (29a. Certifier 1 Certify (Check only one)		basis of exam nner stated.	ination and/or	investigation, i	in my op	inion, death occu	red at the time	, date and	d place, and d	ue to the cause(s)
To t with. To tl	Σ	29b. Signature and title of certification	bler			29c.	License	number 813		29d. Dat	te signed <i>(M</i> o	nth, Day, Year) L 23, 2005 JUMO 21747
H-5		30. Name and address of person	who completed cau	ise of death (I	tem 23a) (Type	Print)	92 F	ns Rn	TE ME	Hac	en Ita	NUMO 21747
Sta Registr	te ar	31. Date filed (Month, Day, Year NOV 2	3 2000	Registrar's Sig	nature	6-41	1	., ., .,		2 1 1 mg		7
HMH 17 Bay 1/2		1978		CAUSEA	13. A							

Registrar

NOV 18

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			State of Maryland / Dep			
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death		No.2009 38849
	Physici		MARY TERESA ROGERS		2. Date of Death Month November	Day Year 3. Time of Death 9:35p M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Tar M			7024 Saw Mill Road	Lusby		Calvert
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 F 102 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 01/23/19	9. Birthplace (State or Foreign Mary Tand
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl	tor	MD Calvert Lusby			1 ∑ Yes 2 □ No
	or 282	Jirec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath wi	lal	7024 Saw Mill Road	20657		U.S.A.
õ	after de	/ Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
15-0036	hours tural",	ed by	3 ¥Widowed 4 □ Divorced Year or Dates:			Specify: Black
CLZI	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: I file Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evarinar must be notified at once.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Maid	king	. Kind of Business/Industry Home
Q Q	filed v Hygid Sther i		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
yland	ould be d Mental narked on	To Be	Louis Carter		ian Hopkin	
<u>=</u>	d 2 st Ith and 27 is n traun		1	ing Address <i>(Street and Number or Ru</i> 4 Saw Mill Road, I		ty or Town, State, Zip Code) 20657
ē,	s 1 an of Hea item 2	Н		osition (Name of ematory or other place)		Location - City or Town, State
Ē	Page nent c ant; if ary or	Hj	1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20/09	Suitland, MD
Бапптог	ermit. eparti nporti ny inj nce.				nowden Fune	
_	w o			246 N. Washington	St.,Rocky	ille,MD 20850
E	Nhalala	0 4	23a. Part 1. Enter the disease, or complications that caused the deat / Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
٠.	Physician /Medical		disease or condition resulting in death) a. Diabets Mellitus Due to (or as a consequence of):			6 vears
7	Examiner					
	red isit	Examiner	Sequentially list conditions if any, leading to immediate course. Lister UI dertyfn i Cause (Disease or injury that initiated events c.			
	ficate be executed physician and s the burial-transit	Exan	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
0/00,	tte be iysicia ne buri	dical	d			
	ertifica ling ph e as th	Med	IF FEMALE:			
מאַ	Attending Physician: The law requires that the death certific redeath. croor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
;	the de	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		
'n	uires that the de	by P	Part II. Other significant conditions contributing to death but not resulting in the u	, 0	23e. Did tobacc	co use contribute to the cause of death?
colds,	w require been signal	ted !	Chronic Obstructive Pulmonary Disease	5	1 ☐ Yes	2 ANO 3 Probably 4 Unknown
֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝ <u>֚</u>	e law r has b e 2 sh	Completed	Chronic Renal Insufficiency		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ן פ	certificate h	_	OF Wassess of such as a su		performed 1 Yes 2X	? death? No 1 □ Yes 2 □ No
5 :	Physician: this certific al director, I	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	Othory	th (Check only one)	6 ☐ Other (Specify)
5 7	ding Ping After thi funeral c	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of	TIL OLI DOA 4 I Nulsing H	28d. Describe how in	
5	eath. or: Ai the fu	catic	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐Yes 2 ☐ No		
	or At after d Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
		Medical Co	29a. Certifier (Check only Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	vithin 2	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
,	1		PT Munich M. D.	D000194	27 11	- 16 - 2009
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	D PRINCE	E FREDERICK .
	Stat		30. Name and address of person who completed cause of death (Item 23a) (Type, ANWAR MUNSHI M.D. SUITE 3. 31. Date filed (Month, Day, Year) 32 Registrar's Signature	130 HOSP. K	U. I I	m D 20678
	Registra		NOV 18 2009 Deven B. So	alled		

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner - ust be notified an once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-trans Hospital or Attending Physician: The law requires that the death certificate be signed by the a P.O. this certificate After ours after death.

neral Director: A
filled in by the fu death.

Box 68760,

of Vital Records,

Division

within 24 hours a To the 2+1

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Frederick Earl Robinson 2009 11, 4:10P Nov. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death P.G. Prince Georges Comm Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Months Days Hours Min 1 **X**M 2 □ F Pa. 79 577-52-3867 11 - 3 - 30Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County Yes 2 No Director N/A Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 U.S.A. Central Avenue, S.E. 5301 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

120 Yes 2 N3/46
If Yes, Give
Year or Dates: 4/54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ₩ Widowed 4 □ Divorced 4/54 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Truck Driver 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria Brown Earl Robinson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7318 Wessex Dr. Temple Hills, Md. 20748 Raymond Robinson/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/20/09 Riverdale, Md. Riverdale Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. to W. Nackon 814- Upshur Street, N.W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal Cardiac Arrhythmia disease or condition resulting in death) Due to (or as a consequence of) Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌂 Unknown Diabetes Mellitus Asthma 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2**X** No 1 ☐ Yes 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D65367 11, 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mehdi Saltarian, M.D. 3001 Hospital Dr. Cheverly, Md. 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 18 2009 parket Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

38851

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physicia	an	1. Decedent's Name (First, Middle, I	,				Month	Day	Year	3. Time of Death
/Medic		WILLIAM DON 4a. Facility Name (If not institution, s	IALD ROBOSSOI	N	4h City Town o	or Location of Death	11	03 2 4c. County		11:15 A M
Examin	er	DEVLIN MANOR N				RLAND			EGANY	
Funeral			S. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			ace (State or Foreign
Director		219-22-8723	¹ X ^{M 2□ F} 81	Yrs.	Months Days	Hours Min.	12/01/1			YLAND
pu >		Usual Residence of Decedent	100 03	y, Town or Lo	ention				10	d. Inside City Limits
aryla shov	'n	10a. State 10b. County PA BEDF		LEARVI					10	1 □Yes 2 XNo
the M	ect	10e. Street and Number	ORD C	THENTY V	10f. Zip Code			10g. Citizen of V	What Count	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is invided Error in court is instiffed and once.	by Funeral Director	400 BEANS COVE	ROAD		15535			U.S.		y .
ns 23	ıera	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Rac	e - America	
or ite	Ful	1 ☐ Never Married 2 ☐ Married	Armed Forces? d 1 X Yes 2 □ No			an, Mexican, Puert Specify:	o Hican, etc.)		ck, White, et	c.
ral",		3 XWidowed 4 ☐ Divorced	If Ŷēs, Give Year or Dates: WWI	I	1 □Yes 2 TNo	эреспу.		Specify	" WHI	TE
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vithin sne. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		JCK DRIVE			CON	STRUC	TON
Hygid v Hygid ther i	e Co	17. Father's Name (First, Middle, La		11(0	JOR BREVE	Г-	ne (First, Middle,			
d be i	B	JOSEPH DOW ROB					A CHERNE			
should nd Mo mark imati	To	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailii	ng Address (Street	l and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zip	Code)
nd 2 sulth a 27 is 27 is r trau		JUNE DOLLY / D		4774	BEDFORD	VALLEY RO	DAD, BED	FORD, P.	A 15	522
s 1 a		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or Tow	n, State
Page Int: If Iry or		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemovai from State		ROCKY GA	1	6/2009	FLIN	TSTON	E, MD
mit.		21. Signature of Funeral Service Lo			2. Name and Addre	ess of Facility				
Depa Depa Impo any ir		Tend 9.	Leochurer			H FUNÉRAL ENE STREE			MD 2	1502
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the death	h. Do not en						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Hone 1	- 1	runhon.	•				Onset and Death
/Medical		resulting in death)	Due to (or as a gonseq	uence of):						gue
Examiner	_	Sequentially list conditions.	b. Ole	ohol	m					ylan
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):						9
and Ltran	хап	that initiated events resulting in death) Last	c Due to (or as a conseq	nence of).						
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death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical		d							
eath certific attending p for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Da	te of deliver	У
death e atte		in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _			Mo	onth [Day Year
uires that the de signed by the a d be detached f	Phys	9 🗆 Unknown	9 🗌 Unknown							
gned gned	by P	Part II. Other significant conditions	s contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?
en siç	edt						1 🗆 Y	⁄es 2 ☐ N o	3 Proba	ıbly 4 ☐ Unknown
law re as be 2 sho	plet						24a. Was autop		Were autop	sy findings available
The ate h	Completed						perfo	rmed?	death?	2 □ No
Physician: The la r this certificate ha ral director, page 2	Be (25. Was case referred to medical examiner?					th (Check only o	ne)		
hysic this c	ဥ	1 Yes 2 No	Hospital: 1 Inpatient 2		III 3 LI DOA		lome 5 Resid)
ing F	:uo	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	rk?	28d. Describe h	now injury occur	red	
teath death tor: / the f	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	A In	and form of]Yes 2□No	OOL Leastien (6	Dan at an el Missa	an an Bural	Davida Number
or At after of Direct in by	Certification:	4 ☐ Homicide determine	ed 28e. Place of Injury - At he building, etc. (Specif	y)	eet, lactory, office		City or Tou	Street and Numb vn, State)	er or nurar	Houle Nulliper,
To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by th completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Gertifying	Physician: To the best of my kno	wledge, deal	th occurred at the t	ime, date and place	and due to the	cause(s) and m	anner as st	ated.
24 hos 24 hos Fun etely	Medical		xaminer: On the basis of examina and manner stated.							
Fo the vithin Fo the Somple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, E	Day, Year)
9+		A Bollin	- Mo		100	017565		Mer. 4	,200	5
, ,		30. Name and address of person when the same address of the same address of the same and address of the same address of the same address of the same and address of the same address of the sa		n 23a) (Type,	Print)	017565 (2V2/e				
nds		A.J. B4/100,	MD 922		they	Celle	MD 2	1502		
Sta Begistr		31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture Agai	Bud	· · · · · · · · · · · · · · · · · · ·				

Baltimore, Maryland 21215-0036

			Ple	ease Type								•			
		_	For State Registrar		e of ivi	aryiano / L		rtment of F			Reg. No	0000	3.8	852	
ı	Physici /Medio		1. Decedent's Name (First, Mi Louis		Ge	rtrude		Renota	S	2. Date of D Month	Da	y 6 aco	3. Time o		
	Examir Funeral Director		4a. Facility Name (If not institute Lions Center 5. Social Security Number 220–10–0339		ab &	Ext. Car le (In yrs. last bir			r Location of Deat berland If Under 24 Hrs. Hours Min.		Pirth	Allega 9. Birti Co We		or Foreign ginia	
	ne Maryland 8a-f show ptified at	ector		nty Llegany	****	10c. City, Tow		berland						City Limits s 2 ☐ No	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, the firm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaminer must be notified at	Funeral Director	10e. Street and Number 515 Rose Hi 11. Marital Status 1 Never Married 2	12. Was		Ever in U.S.		Nas Decedent of H	21502 dispanic Origin? (San, Mexican, Puerl	Specify Yes or No Rican, etc.)		USA 14. Race - Ame Black, White	rican Indian,		
21215-0036	within 72 hours iene. than "natural",	Completed by	(Specify only high	dent's Education whest grade compl	ir or Dates:	16a	Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retire etary De	pation during most of word d)	rking		Specify: Wind of Business/ Hospital	,		
Maryland 2	1 and 2 should be filed v Health and Mental Hygie em 27 is marked other t wther traumatic event, ID	To Be Co	12 17. Father's Name (First, Midd Eli	Asa		Wilfong		3	18. Mother's Nar Grace	E	le, Maide Cliza	n Surname) beth E	ishop		
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Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
,	Physician /Medical Examiner		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	ist only one caus	e on each li	d the death. Do ne.	bra	. /	ng, such as cardia		arrest,		Approxima Interval Be Onset and	Death	
68760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1		a consequence									
O. Box	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 4	Live birth	of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregnand Other (specify)	су		-	23d. Date of del Month	ivery Day	Year	
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant con-	ditions contributing	g to death b	out not resulting i	n the ui	nderlying cause giv	ven in Part I.	1 []Yes 2	use contribute to	obably 4	Unknown	
Vital Records,	sician: The law certificate has l rector, page 2 s	Be Completed	25. Was case referred to med examiner?	ical					26. Place of De	pe 1 □ Yes	topsy rformed? 2 X N	death?	completion of	s available cause of	
of	ath. rr: After	ပ	1 Yes 2 No 27. Manner of Death 1 Natural 5 Per 2 Accident inv	nding estigation	1 ☐ Inpati Date of Inj (Month, Da		utpatier Time of Injury	28c. Inju Woi	Mursing F	lome 5 ☐ Re 28d. Describ		6 ☐ Other (Speury occurred	cify)		
Division	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	al Certification:	4 ☐ Homicide det	fying Physician:	building, e	tc. (Specify) of my knowledg	e, deat	eet, factory, office	ime, date and plac	City or 7	he cause	(s) and manner as	s stated.		
	To the Ho within 24 h To the Fu completely	Medical	one) 29b. Signature and title of cer	tifier	d manner st		nd/or in	29c. Licens	se number		29d. D	ate signed (Mont	n, Day, Year)	(s)	
	3		30. Name and address of pers	son who complete	d cause of	MI) death (Item 23a)	(Type,		55325			ov 06,2	009		
	Sta Begist		31. Date filed (Month, Day, Ye			5 Bisho rar's Signature	g V	Print) Valsh Re	1 Cumbin	rland	MD 2	21502			
	Registi	वा	1007 00	2000	Er. July	1 14. 13	1 000	- Ar mar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

Months

Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

Gaithersburg

25

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day,

July 14,

1984

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2 □ No

Maryland

/Medical Examiner **Funeral**

Physician

1 - For State Registrar

10a. State

MD

5. Social Security Number

212-08-3430 Usual Residence of Decedent

6. Sex

Montgomery

10b. County

t**X** M 2□ F

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it s. it with Examir or must be redified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Medical Certification: To Be Completed by Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit attending physician and for use as the burial-tran After this certificate has funeral director, page 2 s

Division of Vital Records, P.O. Box 68760,

D .	10e. Street and Number		10	f. Zip Code			10g.	Citizen of What C	Country?
2	601 Paradise Cou	ırt		20	877			U.S.A.	
Dy ruile	11. Marital Status 1 ★ Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		es 2□No				14. Race - An Black, Wh Specify: F	
נט	15. Decedent's Edu	ication 16a.		Usual Occi	pation			. Kind of Busines	s/Industry
2	(Specify only highest grad	College (1-4or 5+) 2 yrs	life. DO No	of work done OT use retire Jnemp1	_	working		None	
	17. Father's Name (First, Middle, Last) Trinadad Cruz			*	18. Mother's N		irst, Middle, Maid Ayala	den Surname)	
	19a. Informant's Name/Relationship (7)	vpe. Print) 19b.	Mailing Add	dress (Stree	t and Number or	Rural R	oute Number, Cit	ty or Town, State	Zip Code)
	Trinidad Cruz (Fa	ther) 601	L Para	adise	Court, (Gait	hersburg	J, MD 20	877
	20a. Method of Disposition 1 Rurial 2 Cremation 3 F 4 Dopetion 5 Other (Specify) 21. Sign rule of Funeral Service Trans	AIL So	ouls C	Cemete	ry 11,		09 C	Location - City of Sermanton ERAL HOMI Llle, MD	wn, MD E, P.A.
	23a: Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Findisease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence o	1 A n: Bo	trug		0.0	espiratory arrest,	nia nia a	Approximate Interval Between Onset and Death
1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		pic pregnan				23d. Date of d Month	elivery Day Year
	Part II. Other significant conditions co	ntributing to death but not resulting in	the underly	ing cause gi	ven in Part I.		23e. Did tobacc	co use contribute	to the cause of death?
						_	1 🗌 Yes	2 No 3	Probably 4 Unknown
						_	24a. Was an autopsy performed 1 ☐ Yes 2 💌	? prior to	autopsy findings available ocompletion of cause of
	25. Was case referred to medical examiner?	I Mali				Death (C	heck only one)		
	1 les 2 la 110	lospital: 1 Inpatient 2 ☐ ER/Out		J DOA		<u> </u>		e 6 □Other (Sp	pecify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		jury M		ry at rk?]Yes 2 □ No		. Describe how ir		
	4 Homicide determined	28e. Place of Injury - At home, fari building, etc. (Specify)	·	,,,,,,,,			City or Town, St	tate)	Rural Route Number,
	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occu	irred at the ation, in my	ime, date and pl opinion, death o	ccurred	I due to the caus at the time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
	29b. Signature and title of certifier	MD		0	se number	7	29d.	Date signed (Mor	onth, Day, Year)
ŀ	30. Name and address of person who co	ompleted cause of death (Item 23a) ([vne Print)	- 0	5.00	1		/ /	

State Registrar 31. Date filed (Month, Day, Year) NOV 12 2009

32. Registrar's Signature

Greene St Baltimore, my

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 2009 20:05 Nirma1 Singh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) May 5,1913 Country) India **Director** 96 212-64-2642 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 28a-f 1X Yes 2 No Md. Montgomery Bethesda 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4521 East West Hwy. Apt.1002 20814 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify: Asian Indian 3 x Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) India Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. ပ Mela Devi Singh Labh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620 Deming Ave. Alexandra Va. 22312 Singh (Son) Prem 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Nov.12, 09 Riverdale, Md. 4 Donation 5 Other (Specify) Chambers Crematory 21. Signature of Funeral Service Licenses Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737 som Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna Ectopic pregnancy in the past 12 months? Month Pregnant at time of death ed by the a 2 No Unknown 9 Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy performed? page death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

State

4

30, Name and address of person who completed cause of death (Item 23a) (Type, Print

NG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 3° 200° ar Seiden 1:30 P M .Tacob /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex. 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1477071910 New York Hours 98 535-05-6257 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercipes must be notified at MD Montgomery Wheaton 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20906 United States 3613 Janet Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. orces: ^{2□N}WW II 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government / tral Intelligence Agency I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic event, the once. Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Celia Rickotshine Harry Seiden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12514 Bushey Drive Silver Spring MD 20906 19a. Informant's Name/Relationship (Type. Print) John Seiden - Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 X Removal from State Arlington National 1/21/2010 Arlington, VA 4 □ Donation 5 □ Other (Specify) Edward 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee Arthurs Molles Jamie Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Sepsis. Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and <u>Severe Urinary Tract Infection</u> burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No the detached 9 Unknown 9 Unknown ns certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Colon Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CDiff Colitis 24a. Was an autonsy performe Hospital or Attending Physician: The 1 □Yes 2 X No 1∐Yes 2.2MNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the I

18

31. Date filed (Month, Day, Year) State NOV 1 Registrar

29b. Signature and title of pertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Harold V. Lawson MD 1500 Forest Glen Road Silver Spring MD 20910

29c. License number

D67589

29d. Date signed (Month, Day, Year)

11/04/2009

State of Maryland / Department of Health and Mental Hygieney 38856 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ĩ9, 2009 11:55P.™ Gary Lee SNOKE November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Julia • Manor Health Care Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 11☑M 2□F 73 Yrs. 171-28-7211 August 7,1936 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10b. County wode 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahov the Medical Examinar must be notified at Maryland | Washington Hagerstown 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11400 Stonecroft Court 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) bartender pub Pages 1 and 2 should be filled w itment of Health and Mental Hygie stant: if item 27 is marked other t jury or other treumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Snoke Margaret Wiola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Beam - fiancee 11400 Stonecroft Court, Hagerstown, Maryland 21742 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State November 21 2009 Hagerstown, Maryland injury or Depertment of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eveloro Vasca **Physician** /Medical Due to (or as a consequence of): Examiner extersing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed ianete Due to (or as a consequence of) Box 68760. Physician/Medical ettending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 2 No certificate has Division of Vital 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🖼 ¥No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4"SaNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2323 11-20-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opal Court, Hogerstown, MD 21742 WH-0 Waseem 1126 Dr.Khalin 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - State of Registrar	Maryland		irtment of H <i>tificate of L</i>			giene Reg. No.	2009	38	857
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Donald Alexa	ınder Sk	oencer			2. Date of Dea Month Novemb	Day	5, 2009	3. Time of I	
	Examir Funeral Director		521-60-0232 1፟፟ M 2□F	eer) . Age (In yrs. las 103	st birthday) Yrs.	4b. City, Town, or Burton If Under 1 Year Months Days	Sville If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 11/30/1	h v, Year)	Montg 9. Birth Cou		Foreign
	Maryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery	10c. City,	Town or Lo		tonsvill	0			10d, Inside City	-
	h with the Maryland 3a or 28a-f show st be notified at	al Director	10e. Street and Number 3415 Greencastle Ro	nad.		10f. Zip Code	20866		10g. Citiz	en of What Col		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Funeral		ent Ever in U.S. es? No		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No		pecify Yes or No Rican, etc.)		Race - Amer Black, White Specify:	ican Indian,	เท
21215-0036	C ' 0	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4) 5+		(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired LdUife B	during most of worl)	king		nd of Business/I	ndustry	
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	1 and 2 s Health ar Im 27 is		19a. Informant's Name/Relationship (Type. Print) Grady Lee Jones - Friend 20a. Method of Disposition	20b. Pla	13504	Sherwoodsition (Name of	d Forest		Silv	Dr.	ng, MD	20904
Baltimore,	permit. Pages of Department of Himportant; If Ite any injury or of once.		1 ☐ Burial 2 ② Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee	tate cer	metery, crer Linco	natory or other plac かとれ Cたとmの !. Name and Addres	toru11/20	0/2009 ines-Riv	Bre aldi	ntwood, Funera	Maryla L Home,	ind Inc.
	Physician		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition a.	JU/2 94 used the death. th line.				or respiratory a		er Spri	Approximate Interval Betwoonset and E	e ween
68760, 120	Medical Examiner bhysician and the prival-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events	r as a conseque r as a conseque r as a conseque	ence of):							
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Division	il or Attending Ph after death. I Director: After th d in by the funeral	Certification:	1 ★Natural 5 □ Pending (Month 2 □ Accident investigation 3 □ Suicide 6 □ Could not be continued experiment.	, Day Year)	Injury ne, farm, str	Wor	k? Yes 2 □ No		Street and	d Number or Ru	ural Route Num	aber,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Ce	29a. Certifler (Check only one) 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 29a. Certifler 20a. Certifle	sis of examination								s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	n stated.		29c. Licens	e number 5 4 5 6	6	29d. Date	e signed (Mont	_	
	St. Regist	ate rar	30. Name and address of person who completed causes Sunixha Bho gavilla 31. Date filed (Month, Day, Year) 2. Re NOV 18 2009	of death (Item 2	23a) (Type, Ceo	Print)	nu #1-	·17 518	ven St	wing, r	m D 20	902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6,2009 10:35a November Wardell Scott 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Arcola Nursing and Rehabilitation Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Sex 8. Date of Birth (Month, Day, Year) 1 🛛 M 2 🗆 F Months Days Hours Min 78 249-40-0439 South Carolina June 11, 1931 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tx Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 Urell Place, North East 20017 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 🔀 No Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Presser Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Scott Rosa Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Scott/Daughter 1007 Urell Place, NE Washington, DC 20017 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/14/2009 Brentwood, Maryland 4 ☐ Donation / 5 ☐ Øther (Specify) 21. Signature of Fundal Service bigen ee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Squamous Cell Week Due to (or as a consequence of): Cancer of the Lung Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2**X** No 1 □Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner

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or Attending Physician: The law requires that the death certificate

Box 68760.

P.O.

Division of Vital Records,

Physician

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Director DC

Funeral

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Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

72 hours after

d 2 should be filed within; the and Mental Hygiene.
7 is marked other than "1

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 □Yes 2 □No
0 Hipkneyen

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

25. Was case examiner	referred to medical
1 ☐ Yes	2 X No

28a. Date of Injury (Month, Day, Year) 28b. Time of

27. Manner of Death 1 K Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

NOV 18 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifig

29c. License number D09834

29d. Date signed (Month, Day, Year) November 10, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum, M.D., P.A. 3720 Farragut Avenue, Kensington, Maryland 20895 31. Date filed (Month, Day, Year)

State Registrar

			For State Registrar	State of Maryla		artment d ertificate		nd Mental I	Hygiene Reg. No.!	711114	38859			
	Physici	an	1. Decedent's Name (First, Middle, Las	Sower		2. Date of								
-	/Medic Examir	MedicalDorothy Elizabeth					n, or Location of	Death //	10	County of Dea	1370 1			
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			Usual Residence of Decedent		ity, Town or L			103/2	1/17/	riai				
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	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Mic	ldle, Maiden	Surname)				
Maryland	ould b	To I	Sydney	Simpson			relyn		Deal					
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Motical Evaluation in the mailth of an or other traumatic event, the Motical Evaluation.		19a. Informant's Name/Relationship (7 William A. Sower	* * *		_		or Rural Route Nu Street, C	-					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Removal from State	Place of Disp cemetery, cre	position (Name of ematory or other	of place)	Date	20c. Lo	cation - City or	Town, State			
Itim	artmen artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Light) MD	Vet Ce	m @ Roc	ky Gap	11/18/200	9 F]	Lintsto	ne, MD 1 Home, P.A.			
Ba	Depar Impor any Ir		21. Isignature of Pullerar Septice Elder	dams	5			eet, Cum	_		21502			
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	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):									
o,	icate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):									
8760,	physic the bu	dical	•	d										
Вох 6	leath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy					23d. Date of de	livery			
O. B	e death the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		☐ Ectopic preg			_	Month	Day Year			
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Records,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	ed by						1	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐					
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Vital	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6	Hospital:		26. Place of Death (Check only one)								
10	g Physer this	n: To	27. Manner of Death	28a. Date of Injury	of 28c.		me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred							
sior	Attending I ir death. ector: After by the funer	atio	1 Accident 5 Pending investigation											
27. Manner of Death 1									n (Street an Town, State	(Street and Number or Rural Route Number, own, State)				
City or Town, State) City or Town, State City or Town, State										as stated. e to the cause(s)				
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	MAS		30. Name and address of person who of Vikramaditya	completed cause of death (Ite Poonai, M.D.			Drive, C	Cumberlan	d, MD	21502				
	Sta		31. Date filed NOV 1,6°2009	32. Registrar's Sign	ature	Ked.								

			For State Registrar	State	e of Ma	rylan		artment rtificate				lental Hy	giene Reg. No	7 HH 9	38860
	Physici	an	Decedent's Name (First, Middle	e, Last)	Б.,							Date of De Month	Da	y Year	
	/Medi	cal	Douglas		Dwigh	nt ———		Sho				Novemb		, 2009	10:50 A M
	Examir	Examiner 4a. Facility Name (If not institution, give street and number) 40 Utah Avenue								Location of Location			40	. County of Dea	Allegany
	Funeral		5. Social Security Number	6. Sex		(In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9 Bi	thplace (State or Foreign
ш	Director		219-44-0937	1 🔀 M 2 🗆	F	63	Yrs.	Months	Days	Hours	Min.	11/05/	194	5 Mar	y Land
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	ems	Funeral	11. Marital Status	Arme	Decedent E		S. 13.	Was Deced	ent of Hi	ispanic Or	rigin? (Spe	ecify Yes or No Rican, etc.)	- T	14. Race - Am Black, Whi	
36	s afte	by Fi	1 Never Married 2 Mar	ried 1 🔲 \	res 2. TXNo s, Give	D		1 □Yes 2		Specify:				Specify:	16, 616.
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Mar	12sh ihand 7ism traum		19a. Informant's Name/Relations Robin K. Shook)		1 .	•				al Route Numb rland.		or Town, State, 2 1 502	Zip Code)
e,	1 and Healt em 2		20a. Method of Disposition	/ wile		20b P	1					Pland,		ocation - City or	Town State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ihu Monce.		1 X Burial 2 ☐ Cremation		rom State		Place of Dispo emetery, cren vis Mer					/2009		mberlan	
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	Physician		Immediate Cause (Final disease or condition	,	ETAST		C B	6HJ	D€	R	CA	NCT.	2_		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):												
	Laminer	-	Sequentially list conditions, if any leading to introducts Daw to (or as a nonsequence of):												
	rted nsit	Examiner	Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury		nic (crass	conseq	nence orp								
Ć	exec an and ial-tra	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):												
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89	ertifica ing ph e as th	Physician/Medical	IF FEMALE:	1											
Box	Attending Physician: The law requires that the death certificar death. r death. ector: After this certificate has been signed by the attending pl by the funeral director, page 2 should be detached for use as the	jan/	23b. Was decedent pregnant in the past 12 months?	1 🗆 l	, outcome of Live birth 2	☐ Fetal	death 3	3 ☐ Ectopic pregnancy					0	23d. Date of de Month	livery Day Year
0	he de	ysic	1 □Yes 2 ☑No 9 □ Unknown		Pregnant at t Jnknown	time of d	leath 5	Other (spe	ecify)					Worter	bay rear
σ.	w requires that the d sbeen signed by the should be detached		Part II. Other significant condition	ons contributing	to death but	not resu	ulting in the ur	nderlying ca	use give	n in Part I		23e. Did to	obacco	use contribute t	o the cause of death?
rds	uires n sigr lld be	d by										1 🗆 🗎	res 2	□No 3□F	robably 4 🛛 Unknown
ဝ္	s bee	lete										24a, Was	an	24b. Were a	utopsy findings available
Ä	The law ate has age 2 s	Completed								_	_		rmed?	prior to death?	completion of cause of
ita	slan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?							26. Place	of Death	1 ☐ Yes (Check only o		1 ∐Ye	S Z LINO
of V	hysic this co		1 Yes 2 INo				ER/Outpatien			4 LJ NU	ursing Hor	me 5 Resid	dence	6 □Other (Spe	ecify)
n C	ding Physician: The h. After this certificate h. funeral director, page	ion:	27. Manner of Death 1 ✓ Natural 5 ☐ Pendin	g (Date of Injury <i>Month, Day,</i>	Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe h	now inju	ry occurred	
Division of Vital Records,	death death ctor: / the	Certification: To	2 ☐ Accident investion 3 ☐ Suicide 6 ☐ Could	not be	Place of Injur	v - At bo	ome, farm, stre	M		∕es 2□		OPf Logation //	Otro ot o	ad Alexandras as F	ural Route Number,
ρį	after after Direct	ertii	4 ☐ Homicide determ	ined 200. F	uilding, etc.	(Specif)	y)	set, lactory,	Office		1	City or Tov	vn, State	e)	urai Houte Number,
	spita hours neral y filled		29a. Certifier 12 Certifyir	g Physician: To	the best of	my kno	wledge, death	n occurred a	at the tim	ne, date ar	nd place,	and due to the	cause(s	s) and manner a	s stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On t	he basis of e manner state	examina ed.	tion and/or in	vestigation,	in my op	oinion, dea	ath occurr	ed at the time,	date an	d place, and du	e to the cause(s)
		Σ	29b. Signature and title of certifie	1	7			29c.		number				te signed (Mon	
	5		Huid	0	100	ila			D6	3462			No	vember	4, 2009
	nes		30. Name and address of person Alida Po						ivo	S11 = 4	- 20	5 C.m.	1en1	and, MD	21502
	Sta	e	21 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2						_ ve,	PUIL	UE 20	, cum	nei,T	and, III	21302
	Registra		NOV 0 5	2009	Corrier	A	. par	Mad							

State of Maryland / Department of Health and Mental Hygiene 3886 Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Physician Snyder, III November 8:10 A M Charles Erwin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10914 Washington Holly Terrace Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₩ M 2 □ F 220-64-1613 55 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 27 is marked other than "natural", or items 23a or 28a-f shov r traumatic event, the Medical Experiment the recilled at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 10914 Holly Terrace 21740 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If ten 27 is marked other the any injury or other trainer. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🕱 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔣 No 2 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Erwin Snyder, Jr. Anne Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Friend) 10914 Holly Terrace Hagerstown, Maryland 21740 Joyce L. Hines 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | Nov. 23,2009 Hagerstown, Maryland 22. Name and Address of Facility of Funeral Service Signatur Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer 3 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Month Year Day signed by the a 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₽ been si 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Certification: 28d. Describe how injury occurred Injury at Work? Division 1 🔼 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mulsel Wilm D41667 November 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-4 MiCrac.
31. Date filed (Month, Day, 1) Michael McCormack 11110 Medical Campus Road Hagerstown, Maryland 21742 32. Registrar's Signature State parte Registrar

State of Maryland / Department of Health and Mental Hygiene 38862 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Day 8:15AM Ramona Elaine STAINS 18 2009 Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Homewood Pines Apt. Bldg. Williamsport If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🕱 F 202-20-0829 83 Director June 30, Pennsylvania 1926 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the findical Examination must be notified at Director 1 TYes 21X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 10904 Allen Avenue 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) insurance company executive secretary f Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mody F. Rock Jeannette Culler ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Jones, niece-in-law 17742 Blue Bell Dr., Hagerstown, Md. 21740 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 11/21/09 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME Walit & Van 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sastrointestina disease or condition resulting in death) 1day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atherosclerotic 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy certificate I performe 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation n 24 hours after which the Funeral Director: After the funeral pitch filled in by the funeral 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the P within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D47451 Cynthea Kuther Sands mo November 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Church Road, Hagerstown, Maryland
Cynthia Kuttner-Sands, NO 14214 Paradise Church Road, Hagerstown, Maryland 3H-4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 19 Registrar

			1 - For State Registrar	State of Ma	ryland / De	partmen ertificat	t of H e of L	ealth a Death	and M		Reg. No.	009	388	363
	Physici	an	Decedent's Name (First, Middle, Last,							2. Date of De Month	ath Day		3. Time	of Death
j.	/Medic Examin	al	Hazel Pauline 4a. Fecility Name (If not institution, give Caroline Nursin			4b. City, Den		Location o	of Death	Nov.		2009 County of Dea Carolin		M
Ī	Funeral Director		5. Social Security Number 6. Sec 214-03-6140		(In yrs. last birthda)4 Yrs.	y) If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir	th 1915	9. Bir	thplace (Stet ountry) MD	e or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Talbot		10c. City, Town or Easton	Location								City Limits
	th with the 23a or 284	al Director	10e. Street and Number 516 Pleasant Plac	e		10f. Zip	Code 1601				10g. Citi: US	zen of What C	ountry?	
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other then "natural" or items 23a or 28a-f show marked other then "natural Examiner must be notified at imatic event, it a Maulcal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		3. Was Decedif Yes, specific Yes	cify Cuba	n, Mexican	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify: C	te, etc.	
Maryland 21215-0036	within 72 ho iene. • then "natur it e Mudical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11 H.S. Graduate		(Gi	cedent's Usu ve kind of wo DO NOT u	al Occupa rk done d se retired	ation Juring most	t of work	ing		nd of Business	,	
/land	should be filed wind Mental Hygien Branked other thurstic event, Its	To Be C	17. Father's Name (First, Middle, Last) Frederick Rufus L	ove						e (First, Middle Della Wa		Sumame)		
	d 2 in all the all trau	•	19a. Informant's Name/Relationship (T) Cynthia Draper /							Denton			Zip Code)	
Baltimore,	0 0 == =		20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Dis cemetery, c Denton	rematory or o	ther place	9)		24/09		cation - City of con, MD		
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Ligens	har		22. Name ar Moore F	unera.	s of Facilit	, PA,	12 S. 21	nd St.	, Dentor	, MD 21	629
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of tmmediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each line	the death. Do not e.	the mod	le of dying	g, such as	cardiac	or respiratory a	rrest,		Approxin Interval E Onset an	Between
	Examiner	3r	Sequentially list conditions,	b	consequence of):								/	
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O. Box 68	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (sp					2	23d. Date of de Month	olivery Day	Year
ecords, P.	quires that n signed build be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying o	ause give	en in Part I.			tobacco u Yes 2	se contribute t	o the cause o	
r	rsician: The law requires that the certificate has been signed by th lirector, page 2 should be detache	Completed								24a. Was auto perfe 1 Yes	psy ormed?	24b. Were a prior to death?	utopsy findin completion o	gs available i cause of
Vital	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:			Othe	20	,	(Check only				
Division of	ng Phy fter this neral c	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day)			28c. Injury Work	4 Nu		me 5 Resi 28d. Describe			ecify)	
DIVIS	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, . (Specity)	street, factor	y, office			28f. Location (City or To			'ural Route N	lumber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner state	examination and/or	investigation	, in my or	pinion, dea	nd place, ith occurr	and due to the ed at the time,	date and	place, and du	e to the caus	
	To t To t	W	29b. Signature and title of certifier	- Sik	est	29	c. License	3i	37	76	29d. Dat	e signed (Mon	th, Dey, Year	r)
_			30. Name and address of person who co	es 9.	20 M	e, Print)	ts	st	De	evtc	N	ME	216	.29
	Sta Registi		31. Date filed (Month, Day, Year) NOV 23 2003	22. Registra	r's Signature	Mal								

			For State	State of Maryl					/ 11	09	388	364
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeatn	2. Date of Dea	th	0)	3. Time of	
	Physicia Medi			rilling					-	2009	3:48	a ^M
9	Examir	ner	4a. Facility Name (if not institution, give si Anne Arundel Medi	,		4b. City, Town, or Annap	Location of Death		4c. County Ann	of Death e Aru	ındel	
	Funeral Director		5. Social Security Number 6. Sex 577-07-9301	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 27	Year) 1911	Count	lace (State or ry) ingtor	
	nd at	Ļ	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Loc	eation	1	NOV: 27			Od. Inside City	
	Marylar 28a-f sl otified	Director	Maryland Mont	gomery	-	er Sprin	g			"	1 Tes	
	ith the 3a or 2 t be no		10e. Street and Number			10f. Zip Code			10g. Citizen of V		try?	
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980	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fledical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🏲 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 19	"	Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexican, Puerto	Rican, etc.)	Blac	White, e	tc.	
5-0	2 hour "natur	plete	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	ent's Usual Occup	ation Juring most of work	ina	16b. Kind of B			
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	ye 1 and 2 should be filed within 72 hour t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last) Henry Tri	lling			18. Mother's Nam	ne (First, Middle, N	Maiden Surname	,		-
Maryland	nd Mer marks marks		19a. Informant's Name/Relationship (Typ		19b. Mailin	a Address (Street a	and Number or Rur	al Route Number			ode)	
	nd 2 sh ealth a m 27 is		James H. Trilling/	Son			ms Circl				,	
Baltimore,	Page 1 and the Hambert of Hambert If itelements of the ury or other thanks or other thanks or the hambert and hambert and the hambert and the hambert and hamb		20a. Method of Disposition 1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State G	b. Place of Dispos cemetery, crem ate of H	sition (Name of atory or other plac eaven Ce	metery 1	Date N2009 ²⁰	20c. Location - Silver	•)
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	الم	22	Hame and Address	jof February ersity B	ns Funer	al Home Silver	Inc.	ng. MI	209
6	Physician/ Medical Examiner	Examiner	23a. Part 1 There the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury)	Due to (or as a cons	ation sequence of):		umoni		J.,		Approximate Interval Betw Onset and D	een
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Division of Vital Records,	sician: The law certificate has I rector, page 2 s	Completed						24a. Was ar autops perforr 1 \(\sum \) Yes	ned2	orior to com death?	sy findings av pletion of ca	allable use of
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of V	ig Phys ter this neral di	te: To	27. Manner of Death	1, Impatient 2 28a. Date of injury (Month, Day, Year	ER/Outpatient 28b. Time of injury	28c. Injury	4 □ Nursing Ho	ome 5 Reside 28d. Describe ho				
sion	I or Attendin after death. Director: Afi I in by the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A			Yes 2 No	006 + i /04		D	2	
Divi	tal or Arrs after al Director		4 U Homicide determined	building, etc. (Spe	ecify)			28f. Location (Str City or Town	, State)			,
	To the Hospital or Attending Physician: within 24 hours after deals within 24 hours after deals of the Funeral Director. After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check only one) 3 Certifying Physic 2 Medical Examine 3 Certifying Myse	ian: To the best of my kner: On the basis of examina Practioner: To the best o	owledge, death o ation and/or investi f my knowledge, d	ocured at the time, gation, in my opinio eath occurred at the	date and place, ar n, death occurred a time, date and place	d due to the caus t the time, date and ce, and due to the	se(s) and manne d place, and due cause(s) and ma	er as stated to the caus inner as stat	se(s) and man	ner stated.
			29b. Signature and title of certifie	0/2		29c. License			9d. Date signed			
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	Stat Registra		31. Date filed (Month, Day, Year) NOV 17 2009	32 Registrar's Sig	inative de a	Kad						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registras MFND#10eper INF, 11/19/09, BMN, MCCo 38865 Certificate of Death Reg. No 2 U U 9 1. Decedent's Name 2. Date of Death November 5, 2009 2:50A. IRENE TASHLICK 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Dec. 19, 1927 9. Birthplace (State or Foreign 1 □ M 2 🂢 F Months Days Hours Min. New York 81 054-20-3824 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Gaithersburg Montgomery 1 ☐ Yes 2 No Maryland 109 Street and Number 917 Booth Street, Apt 325 10f. Zip Code 10g. Citizen of What Country? 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Vivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Statistician State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Israel Katz Gussie Sesser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16639 Killdeer Drive Derwood, Maryland 20855 19a. Informant's Name/Relationship (Type. Print) Hannah Tabeka -daughter 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Garden of Remembrance 11/6/2009 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complic to ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Strokes disease or condition resulting in death) Due to (or as a consequence of) Septic emboli 3 davs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Venous ulcers that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Lymphocytic Leukemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? V. autopsy perform ormed? 2 ☑No 1 ☐Yes 2X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 X npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural

/Medical Examiner law requires that the death certificate be executed burial-transit and attending physician for use as the burial signed by the a page 2 should certificate

Box 68760.

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Division of Vital Records,

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depa trnent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Ir jury or other traumatic event, Ite Medical Examinet must be notified at

John CK, Cene Janote, Maryand 21215-0036

IF FEMALE: 23b. Was decedent pregnant

27. Manner of Death 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

M1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinni Juneja, M.D. SH 8600 Old Georgetown Road Bethesda, Maryland 20814 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Pay 1 2009 Physician/ 10:23 PM THOMAS JOHN LESLIE Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth May 14, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 🗆 T918 Tennessee 91 415-10-9150 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland rector 1

Yes 2 □ No Maryland Frederick Frederick Ξ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 412 White Oak Place 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ☐ Widowed 4 X Divorced WWII Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Jeanne Bussard Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ပ္ Inez Thomas Parker Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8022 Old Receiver Road, Frederick, MD 21702 Rickey L. Thomas / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 11/16/09 Frederick, Maryland Olivet Cemetery Mt. 4 Donation 5 Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, ar 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FIBUILLATION VENTILLULIAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ∐ Yes 2 L 9 ☐ Unknown the cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of De th 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

4+1

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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KAREN HUNDEMER

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Dan

NO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

0394444

THOMAS JOHNSON DONE SUIDE

29d. Date signed (Month, Day, Year)

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		4	For State	State of Ma	ryland / [Depa <i>Cert</i>	rtment of H tificate of D	ealth and <i>eath</i>	d Mental Hy	giene _{Reg. No.} 2	009	38867
			Registrar 1. Decedent's Name (First, Middle, Last,						2. Date of Dea	ath		3. Time of Death
	Physicia Medic		Lois Jane TRITSCH	[Novem k	OPR 2	Year 2009	5:30 PM
	Examin		4a. Facility Name (if not institution, give s				4b. City, Town, or-	-	ath		ounty of Death	4
-*			Washington County		In um last hirtl	holovi	Hager	stown If Under 24 H	Irs. 8. Date of Bird		Washing	blace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sec. 1 [(In yrs. last birtl 33	Yrs.	Months Days		in. (Month, Da Feb. 1	1. Ye <i>ar)</i> 1. 19	26 Mar	yland
			Usual Residence of Decedent									
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	ith th		1066 S. Potomac S	Street			2174	0			USA	,
	eath v	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	/as Decedent of His Yes, specify Cubar	spanic Origin?	(Specify Yes or No-	14	1. Race - Americ Black, White,	
36	ifter d ", or i		1 Never Married 2 Married	1 Yes 2 X N	lo	1	☐ Yes 2 🔀 No		, , , , , , , , , , , , , , , , , , , ,	Sp		nite
Š	ours a atural	Completed by	3 🕅 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates.	16a.	Deced	ent's Usual Occupa	ation		16b. Kind	d of Business In	
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21	withii giene ner th t, the		Elementary/Seconday (0-12)	0 "		hom	emaker				er own	nome
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at <u>once.</u>	To Be	17. Father's Name (First, Middle, Last) Grover Cleveland	Williams					Name <i>(First, Middle,</i> Kate Gr u		irname)	
Ž	ould b nd Me mark matic	ľ	19a, Informant's Name/Relationship (Ty		196	. Mailin	g Address (Street a	nd Number or	Rural Route Numbe	er, City or To	own, State, Zip (Code)
Ž	d 2 shalth ar		Ann L. Moats - da	aughter	_ 9	1 M	iranda Co	ourt, M	artinsbur	g, WV	25403	
altimore,	of He of He if item		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3	Removal from State	cemete	ry, crem	sition (Name of natory or other plac		Date / 0.0		ation - City or To	
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Bal	permit Depar Impor any in		21. Signature of Funeral Service Licens	Acu			. Name and Addres		d., Hage:			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused	the death. Do r							Approximate Interval Between
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	To the Hos within 24 ho To the Fun completed	Ž	only one) 3 L Certifying Nur. 29b. Signature and title of certifier	se Practioner: To the	best of my know	wieage,	29c. Licens		a place, and due to		e signed (Month,	
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	11.72		30. Name and address of person who					وس	12m/2	9		1747
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requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760, physician the attending pl signed by the a page 2 s director, this After Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

the

Baltimore, Maryland 21215-0036

3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

29b. Signature and title of certifier

y del State Registrar

31. Date filed (Month, Day, Year) NOV 0 6 2009



29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D26907 BISHOPWALSHED CUMBERLANDAD

DHMH 17 Rev 1/2001

			for State Registrar	State of Ma	aryland / De <i>C</i>	partment of ertificate of	Health and <i>Death</i>	Mental Hy	/giene2 0 0	9 38869
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of D Month		3. Time of Death
-	/Medi Examir	cal	IRENE P	TYLE e street and number)	R	4b. City. Town.	or Location of Dea	ath	4c. County of	7 2.00
	Examin	lei	Coastal Hospice	1 11	Lake	Salis	bury			mico
	Funeral Director		5. Social Security Number 6. S 1 212-12-2542	ex	(In yrs. last birthda 91 Yrs	Months Davs	Hours Mii		orth (Pay, Year) 9 25, 1918 Ma	Birthplace (State or Foreign Country) aryland
	put w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
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	th the or 28a	Director	10e. Street and Number	sec		10f. Zip Code	SLICIG		10g. Citizen of Wha	at Country?
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Modical Exeminer must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:	i i	3. Was Decedent of If Yes, specify Cut 1 □Yes 2 □XNo	oan, Mexican, Pue	(Specify res or Nerto Rican, etc.)		American Indian, White, etc. White
215-0036	72 hor	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	i (G	cedent's Usual Occu	during most of w	orking	16b. Kind of Busin	ness/Industry
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Maryland	d2sh thand t7 is π traum		19a. Informant's Name/Relationship (,					ber, City or Town, Sta	
ē,	s 1 and if Heal item 2 other		Nancy E. Drewer (1 20a. Method of Disposition	Daughter)		2 William sposition (Name of rematory or other pla		ond Rd. Date	- Delmar, 20c. Location - Cit	MD 21875 by or Town, State
mo	Page: nent o ant: If ary or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			e Memorial I	i	13, 2009	Crisfield	, Maryland
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service Licen	2 . 1	21/	22. Name and Addr	ess of Facility	BRADSHAW	& SONS FU	JNERAL HOME
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8760,	icate be executed physician and the burial-transit	dical		d						
O. Box 6	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of Month	
<u>P</u> .	that the		Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
Vital Records,	w requires that the disben signed by the should be detached	ed by	1					_ 1□	Yes 2 No 3	☐ Probably 4 ☐ Unknown
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E B	: The law cate has t	Com						ner	formoed? dea	ith?]Yes 2년No
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sion	endin eath. or: Aff	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 □ No			-;
Division	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could n ot be determined	28e. Place of Inju building, etc	ry - At home, farm, c. (Specify)	street, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Ce		ysician: To the best of the basis of and manner sta	examination and/o	r investigation, in my	opinion, death oc	curred at the time		
	To the within 2 To the Comple	Mec	29b. Signature and title of certifier	and mariner Sta	iod.	29c. Licer	se number		29d. Date signed (Month, Day, Year)
	XTJ		1				100584	10	11/11/	09
	6+1		30. Name and address of person who	1 0	eath (Item 23a) (Typ	29c. Licer Dee, Print) 3 SAC	1.0		4 -5 1	717
	Sta	te.	31. Date filed (Month, Day, Year)	V	r's Signature	SSAC	23 CH	y m	2 01	0 - 2
	Regist		NOV 12		und a A.	back				

P.O. Box 68760. Records, Division of Vital To the Hospital or Attend within 24 hours after death To the Funeral Director;

completely

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and the of certifier

Descripting Physician: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 042892

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chuidian

Little Paturent Parkway Columbia MD 31044 10724

		. ,				9		
	For	State of Maryland /	Depa	artment of Health and M	lental Hygie	ene		
-	For State Registrar		Cer	tificate of Death	Reg	. No.2 0 0 9	3887	
1. I	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death	
(CAROL	TABLER	W	ESTBROOK _	NOVEMB	ER 4 2009	20:16	М
4a.	Facility Name (If not institution, give s.	treet and number)		4b. City, Town, or Location of Death		4c. County of Death		

Physician /Medical Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

er	The Johns	Hopkin	s Hospital			Balti	more	City						
	5. Social Security N 215-72-97		6. Sex 1 □ M 2 🗓 F	7. Age (In yrs. la 52	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Day May 1	rth ay, Year) 7 , 195	57	Cor	hplace (State or Foreign intry) hington D.C.
	Usual Residence of			10.00	~									10d. Inside City Limits
lor	10a. State Maryland	10b. County Monts	gomery		, Town or Le rmante									1 ☐ Yes 2 XNo
rec	10e. Street and Nur		,			10f. Zip	-Code	····			10g. Cit	izen of V	Vhat Cou	untry?
Funeral Director	13529 Wal		od Lane				208	74			_	ited		
uner	11. Marital Status	- A Million	Armed Fo		5. 13.	Was Dece	dent of H cify Cuba	ispanic Or n, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.))-		e - Amei k, White	rican Indian, e, etc.
by	1 Never Marri		If Yes Giv	re		1 🗌 Yes	2 🔀 No	Specify.				Specify	/: W	hite
Completed	(Spec		nt's Education est grade completed)		(Give	edent's Usu	ork done i	during mos	st of work	ing		(ind of Bu		Industry County
ршо	Elementary/Seco	ondary (0-12)	College (1	-4 or 5+)		ם מס אסד ש raedu		•						iools
Be C	17. Father's Name		Last)							e (First, Middle		n Surnan	ne)	
일	Robert 1	[abler			,					et New				
	19a. Informant's Na		ship <i>(Type.Print)</i> Vestbrook(Unchand	1	•	•			ral Route Numi				(ip Code) 20874
			West Diook (1			woou.						Town, State
	20a. Method of Disp 1 X Burial 2 4 □ Donation	☐ Cremation	3 Removal from	State Co	lace of Disp emetery, cre locacy	ematory or o	other plac		Nove	Date Ember 2009			-	e,Maryland
	21. Signature of Fu			\					-	Vol Fur	nera]	L Hor	me	
	MA	2/5	the	М00	689	10 Eas	st De	eer P	ark	Dr. Ga	ither	rsbu	rg,	MD 20877
			complications that only one cause on e	au the death ach line.	. Do not en	iter the mod	de of dyir	ig, such as	cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of):										511	Oriset and Death		
	resulting in death)		Due to			MANIA	6							
ner	Sequentially list con if any, leading to im cause. Enter Unde	nditions, imediate	b. Due to	OTROF (or as a consequ	ience of):									
Examine	Cause (Disease or that initiated events	injury	a. ALU	TE MY	ELU	GEN	ous	LE	UK	EMIA				
	resulting in death)	Last	Due to	(or as a consequ	ience of):									
edic			d											
n/M	IF FEMALE: 23b. Was decedent	t pregnant		tcome of pregna								23d. Dat	te of del	ivery
Physician/Medical	in the past 12 1 ☐ Yes 2			birth 2 Tetal nant at time of de		☐ Ectopic ☐ Other (s _i		у				Мо	nth	Day Year
Phy	9 Unknown	flacet sanditi	ons contributing to d		Uting in the	underlying	Cause di	ven in Par		23e Did	tobacco	use cont	ribute to	o the cause of death?
d by	Part II. Other signi	ncant conditi	ons continuing to c	leath but not rest	and g in the	underlying	cause gi	ven in r ai	. 1.					obably 4 Unknown
lete										24a. Was	an	24b.	Were au	topsy findings available
Completed										auto perf	opsy ormed? 2 V No		death?	completion of cause of
Be C	25. Was case refer	red to medica	ı					26. Place	e of Death	n (Check only	_/~	1		
일	examiner? 1 XYes 2	No	Hospital: 1	Inpatient 2 🗆	ER/Outpatie	nt 3 🗆 D	Oth	er: 4 🗌 N		me 5 🗆 Res			_	cify)
	27. Manner of Deat 1 Natural	5 Pendi		of Injury th, Day Year)	28b. Time Injury		28c. Injur Work	< ?		28d. Describe	how inju	iry occur	red	
icati	2 Accident 3 Suicide	6 Could		of injury - At ho	me, farm, st	M treet, factor		Yes 2 🗌	NO	28f. Location	(Street a	nd Numb	oer or Ri	ural Route Number,
ertil	4 Homicide	detern		ing, etc. (Specify,						City or To				
Medical Certification:	29a. Certifier (check only one)		ng Physician: To the Examiner: On the b end mar											
Me	29b. Signature and	title of certifie				29	c. License	number			29d. Da	ate signe	d (Monti	h, Day, Year)
	1.2	-	3		MIT		RES	00	X		NOV	EMF	3ER	4,2009
	30. Name and add	ress of persor	who completed cau	se of death (Item	23a) (Type							<u> </u>		

DHMH 17 Rev 1/2001

State Registrar

parks

600 North Wolfe St, Baltimore, MD, 21287

09-09012 Noel White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	VVIIIC		- For State Criticate O Certificate O Certificate O			Reg	. No.	
	Physicia		Decedent's Name (First, Middle,Last)			Date of Death Month	Day Year	3. Time of Death 0629 hrs
/led	ical Exami		Noel White	T. 611 - W	Learning of Dag	November 2	20, 2009 4c. County of Deat	
	7.		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Annapolis	Location of Dea	ın	Anne Arundel	
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yea	r If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	thplace (State or
	Director		214-27-6195 1 M 2 XF 19 Yr	Months Day	s Hours M	DEC. 4	, 1989 Forei	ountry) Maryland
0	ow any	ı	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local					10d. Inside City Limits 1 Yes 2 X No
7	yland -f sho	ä	Maryland Montgomery Germantown 10e. Street and Number	10f. Zip Code		100	g. Citizen of What Cou	intry?
	ith the Maryland 23a or 28a-f sho notified at once.	ē	12447 Great Park Circle #107	20876		111	nited Stat	00
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. W	vas Decedent of His		Specify Yes or No-	14. Race - Ame	rican Indian, Black,
	death r item	Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No	Yes, specify Cubar	n, Mexican, Puei	to Rican, etc.)	White, etc.	
	after	by F	or Dates:	Yes 2 X No		fundi dana	Specify: Cau 16b. Kind of Business	
	hours natur Exam	B.		ent's Usual Occupa most of working life			Top. Kind of business	industry
	, MD 21215-0036 and 2 should be filed within 72 hours afterealth and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner	Completed	11 Stude	ent			Education	
	MD 21215-0036 dt 2 should be filed within 7 dith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	Š	17. Father's Name (First, Middle, Last)		18.Mother's Na	me (First, Middle, M	aiden Surname)	
	215 be fill mtal H rked	Be	Bruce Towers White			nn Read		
	hould hould hould is ma	은	(),, , , , , , , , , , , , , , , , , ,	•				e, Zip Code) 20876
	e, MC l and 2 sl Health ar item 27		Dawn White, Mother 1244 20a. Method of Disposition 20b. Place of Disp		emetery.	Date	, Germanto 20c. Location - City of	
	Baltimore, permit. Pages I an Department of Hea Important: If iter		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)	l Ne	ov. 22,	Clan Purn	io MD
	ti. Pag		21 Signature of Funeral Service Licensee	. Cremato	s of Facility	009	Glen Burn	
	Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27		Them MO1508	hibadeau	Mortua:	ry Service	e, P.A. Spring, M	D 20910
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente	r the mode of dying	, such as cardia	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
1	M_dical laminer	8 1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic (heroin) is Due to (or as a consequence of):	ntoxicati	on			Death
			Sequentially list conditions, b					
		in	if any, leading to immediate Due to (or as a consequence of):					944
	760, cate be executed physician and the burial - transit	l Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.					
	e exec cian al trial - t	Medical	X UNPENDED 23a,27,28a-f,	permE, g8	398 12/2	9/09 TT		
	760, Teate be ex. 3 physician the burial	₩.	IF FEMALE: 23c. If yes, outcome of pregnancy		Ectopic pre		23d. Date of delive Month	ery Day Year
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	Physician/	past 12 months?	Fetal death 3 Other (Specify)		gnanoy		
	that the d detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause	given in Part I.			to the cause of death?
	ds, I equires een sig ould be	Completed			-	24a. Was a		autopsy findings available
	COF	l du				autop perfor 1 ✓ Yes	med? death	
	Re ifficate or, pag	ပိ	25. Was case referred to medical	26.Pla	ce of Death (Che		2 10 1	103 2 110
	/ital /siciar siciar is cert	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie	ent 3 DOA	Other Nu	rsing Home 5	Residence 6 Ot	ner:
	of \oferstanding Of \overstanding Of \ov	ř	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time		jury at Work?		now injury occurred	-
	ion tendin eath. tor: A	aţi	Natural 5 Pending Fd 11/20/09 Fd 5:	45 am	Yes 2X No	unk	·	
	Division of Vital Records, P.C pital or Attending Physician: The law requires that ours after death. reral Director: After this certificate has been signed filled in by the funeral director, page 2 should be dete	Certification:	3 Suicide 6 X Could not be determined (Specify) found at res		e building, etc.	28f. Location (S	Street and Number or state) 2620 R1	Rural Route Number, City Va Road
	Ospital hours uneral ly filled		4 Homicide		data and place			
	Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	igation, in my opini	on, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To the within Comple	Med	and manner stated. 29b, Signature and tipe of cedifier		nse number		29d. Date signed (i	
4	3-PEN		Tieth Here West	0.0	C.M.E.		November 21,	2009
			30. Name and address of person who completed cause of death (Item 23a)					
			Victor Weedn MD JD Assistant Medical Examiner 11	1 Penn Street,	Baltimore, N	/ID 21201		
	s	tate	31. Date filed (Month, Day Year) NOV 2 4 2009 Registrar's Signature	wed				

State of Maryland / Department of Health and Mental Hygiene-For State Registra 38873 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Jane Fay WOLFE 7:14a4. /Medical November 20, 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Health Care Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 11, 1 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔯 F Director 218-24-8812 80 Yrs. Ĩ929 Maryland Usual Residence of Decedent Maryland al Hygiene. I other than "natural", or Items 23a or 28a-f show ivent, tha Madical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1XYes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Willard Street 21740 U.S.A. filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 8 homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi Pau1 Beard Clara B. Hawthorne 2 19a. Informant's Name/Relationship (Type, Print) , 1 and 2 st of Health ar fitem 27 if 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Wolfe - husband 209 Willard Street, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery November 24, 2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Walit SUCa 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 0 /Medical Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and doe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant; conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçoo use contribute to the cause of death? should be Completed Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place Death Check only one Hospital: Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Whursing Home 5 Residence 6 Other (Specify) After thi funeral of 27. Manner at Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deat To the Funeral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifié 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person impleted cause of death (Item 23a) (Type, Print) antistan DH - 2 SIDD 31. Date filed (Month, Day, Year) NOV 23 State Registrar

38874 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** Day Year 14, ISABELL WRIGHT NOV. 2009 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CRESCENT CITIES CENTER PRINCE GEORGE'S RIVERDALE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🗓 F **Director** 929-23-2955 86 APRIL 16,1923 WASH. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examinating the profile of once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyres 2 □ No MD. PRINCE GEORGE'S MT. RAINIER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4004 37th ST. 20712 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 HOUSEKEEPER DOMESTIC 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM ပ WHITE ESTELLE TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBEN B. LOGAN BOWMAN/DAUGHTER 4004 37th ST., MT. RAINIER, MD. 20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 11-19-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Chame M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANTEMOSCUENOTIC CANDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) he lay requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): CERTIFICATION A P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 FIB TILLATION cate has been si page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Chronic Obstructive lung 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Lett +10:05,60/AL certificate 1 □Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1. Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 01852 reenstry Rd Mysatter The Mis 20181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URE MA 6101 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. N2 009 38875 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Elton Berry Weber November 17,2009 4:05 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Retirement Village Williamsport Washington Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖺 F Months Days Hours Director 319-03-8814 October 14,1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov Ita Modical Exartine must be richfied at Directo 1 ☐ Yes 2 🛱 No Maryland Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13721 Clear Spring Road 21722 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No þ Specify: 3 Nidowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If a Mones. College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Berry Doub ၉ June Shewbridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merry Gehr (Daughter) 13721 Clear Spring Road Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park | Nov.19,2009 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) OSBOTTNE Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 23d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner month Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been siç ; page 2 should b Completed 1 ☐ Yes 2 📉 No 3 Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐Yes 2 ☐ No 2 **X**(Vo To the Hospital or Attending Physician:

within 24 hours after death.

Jo the Funeral Director: After this certification completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Northern

31. Date filed (Month, Day, Year) NNV 18

AUe

DHMH 17 Rev 1/2001

0

cause of death (Item 23a) (Type, Print)

Registrar's Signature

HAGERSTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.00

			1 - For State Registrar	Otato of Marylan	Cei	rtificate of L	Death		Reg. No.	09	38816
,	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ıth Day	Year	3. Time of Death
	Physici /Medi		tunice V	Weems				November	13	2009	7 03 PM
	Examir	ner	4a. Facility Name (If not institution, give			D	Location of Death	1.		y of Death	
-	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthol	lace (State or Foreign
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director			□M 2 ⊠ °F	75 Yrs.	Months Days	Hours Min.	(Month, Day January 1	, Year)	Coun	try)
	yland Iow at		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1/	0d. Inside City Limits
	Mar a-fst iffied	cto	MD Calvert	Lu	sby					ļ	1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number		· -	10f. Zip Code		1	10g. Citizen of	What Coun	try?
	ath w	Funeral Director	12590 Olivet Road			20657	·		USA		
	item item	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	.S. 13.	was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	city Yes of No- Rican, etc.)	Bla	ce - America ack, White, e	
920	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	þ	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specia		lack
5-0036	72 ho natur tical l	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Occupa	ation during most of workii	30	16b. Kind of E		
2	12 should be filed within 's hand Mental Hygiene. 7 is marked other than "fraumatic event, the Med	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I						
d 21	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	22		Cus	todian 18. Mother's Name	(First, Middle,	Janitoria Maiden Surnai	_	
an	ld be ental ked o	To Be	Leroy Sutton							,	
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ng Address (Street a	Lucinda Sa and Number or Rura		r, City or Town	ı, State, Zip	Code)
	and 2 ealth a n 27 is		Fern Jeffers	son - daughter	P.C	Box 320	Solomons J	MD 20688	8		
ore	Jes 1 t of Hr If iten or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □		lace of Dispo cometery, crer	sition (Name of matory or other plac	re)	ate	20c. Location	- City or To	wn, State
Baltimore,	t. Pag rtmen rtant:		4 □ Donation 5 □ Other (Specify		utton Ce	metery	Novembe	r 21, 2009	usby, M	D	_
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	l 00		. Name and Addres	Sew	ell Funera			
н			23a. Part1. Enter the disease, or comp	lications that caused the deat			Beach Rd., F g, such as cardiac of			D 2067	Approximate Interval Between
19.55	Physician		shock, or heart failure. List only o	1.01	\ \	0.				- 1	Onset and Death
	/Medical		disease or condition resulting in death)	a. Lett low Due to (or as a conseq		or pher	monic				
×	Examiner		Sequentially list conditions	b							
1	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Unter Unidenying Cause (Disease or injury	Due to (or as a conseq	uence of):						
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):					-	
68760,	sician buris	al E		d							
68	tificate be executed ig physician and as the burial-transit	Medical		u							
Box	ath cel	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)				ate of delive onth	ry Day Year
P.0	at the by the tached	hys	9 ☐ Unknown	9□Unknown							
	uires that the de signed by the a Id be detached to	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en în Part I.	23e. Did to			e cause of death? ably 4 □Unknown
Records,	w requir been si should	Completed						24a. Was a	n 24h	Were auto	nsv findings available
Re	The lav	dmo						autops	med?	death?	psy findings available npletion of cause of
or Vital		Be C	25. Was case referred to medical examiner?				26. Place of Death		2⊠No ne)	1 🗆 Yes	2 2 (No
<u>z</u>	hysic his ce Il direc	ToE	1 ☐ Yes 2 No		ER/Outpatien		4 □ Nursing Hor	ne 5 Resid	ence 6 □Ot	her (Specify)
o u	ing P After t unera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe h	ow injury occu	rred	
Division	death ctor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At ho	ome, farm, str		Yes 2 □ No	98f Location (S	treet and Num	her or Rura	l Route Number,
Div	after Direct	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	oot, laotory, omoo		City or Town	n, State)	Der Or Fibra	rroute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 CertifyIng Phy 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ded at the time, d	cause(s) and m	anner as st	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License	e number	2	29d. Date signe	ed (Month, i	Day, Year)
			- Costin	ms		00	07594		Novemb	n 15	,2009
11	211) 1		30. Name and address of person who o	ompleted cause of death (Iten	23a) (Type,	Print)					
a	(m 9		Chery Hepp, MI 31. Date filed (Month, Day, Year)	32 Pagintanta Si	oftel Te	Road, Kr	ince tred	wick, N	10 30	2678	
	Sta Registi		NOV 1	ompleted cause of death (Iten 100 Hos a 32. Registrars Signs 7 2009 August	J.	backer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ui yiai ic	•			Death			2009	38877
	Physici		1. Decedent's Name (First, Middle, Las Joh	•	Zavro	i.s				2. Date of De Month Novemb	Day	9. 2009	3. Time of Death 6:05 p M
4	/Medic Examin		4a. Facility Name (If not institution, give				4b. Cit	, Town, or	Location of Death			County of Deat	
-			Holy Cross Hos					Silv	er Sprin	9			gomery
	Funeral Director		150-22-4868	ex 7. Age	e (In yrs. la 87	st birthday) Yrs.	If Und Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/18/	th 1922 1922	9. Birt Co Neu	hplace (State or Foreign untry) Jewey
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Maryl f sho	to	Maryland Montgome	אונו				Si	lver Spr	ina			1 □ Yes 2 💆 No
	r 28a	irec	10e. Street and Number]			10f. 2	ip Code		5	10g. Citi	izen of What Co	untry?
	th with	al D	12813 Layhill	Road					20906			u.5	S.A.
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any loury or other traumatic event, the Medical Evanthrar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 🔯 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give				edent of H ecify Cuba 2 🛣 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White Specify:	e, etc.
21215-0036	hours ural",	q pe	3 Widowed 4 Divorced	Year or Dates:		16a. Deced	tantic i le	ual Occum	ation		16h Ki	ind of Business/	White
7	in 72 "nat	plete	15. Decedent's Ec (Specify only highest gra			(Give	kind of w	ork done o use retired	during most of worl	king	100. KI	ind of business/	inoustry
212	yiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)	Lead	Ban	quet	Manager		Ho?	tel Serv	vices
b	al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)		•				18. Mother's Nam	ne (First, Middle	Maiden	Surname)	
ylaı	Ment Ment arked aric e	To	Pete	er John Za	vras				Kathe	rine Paj	oatho	opoulos	
lar	2 sho and is ma		19a. Informant's Name/Relationship (•	•	and Number or Ru		-		
e, 1	1 and Health em 27 ther t		Soula Zavras -	Spouse	20h Pl					Uver Si		g, Marry ocation - City or	Land 20906
Baltimore, Maryland	ages ant of t: if it		1 Burial 2 ☐ Cremation 3 ☐			ace of Dispo						,	,
Ħ	artme ortan Injur		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licentary)						n. 11/1 ss of Facility <i>H</i> ;				l Home, Inc.
ñ	Depar Impor any ir	Ų.	Namen A.	104101	7								ng, MD 20904
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused	the death.								Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition			n Pneu							1-2 weeks
-A	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
	Ladillilei	_	Sequentially list conditions,	b. End-S			ime	i's D	ementia				Months
	uted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequi	erice oij.							
Ć,	execuna and iai-tra	Exal	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):							
68760,	rificate be executed by physician and as the burial-transit	ledical		.d									
		Medi	IF FEMALE:										
Вох	eath cert attendin for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗆 Fetal	death 3		pregnanc	ry		1	23d. Date of de Month	livery Day Year
o.	The law requires that the death cer ate has been signed by the attendit page 2 should be detached for use	Physician/N	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	eath 5	Other (specify)					
σ.	w requires that the d been signed by the should be detached	/ Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resul	ting in the ur	nderlying	cause giv	en in Part I.	23e. Did 1	tobacco u	use contribute to	the cause of death?
ds	uires n sign ld be	d by	Hyper	tension						1 🗆	Yes 2	□ No 3□ P	robably 45 Unknown
OS	s bee	lete								24a. Was		24b. Were au	utopsy findings available
Re	The law te has age 2 s	Completed								auto perfo 1 □Yes	psy ormed? 2 Al	prior to death?	completion of cause of
ita	ian: '	Be C	25. Was case referred to medical examiner?						26. Place of Dea			, , , , , , , , , , , , , , , , , , , ,	2200
Ž <	hysio		1 Yes 2 No	Hospital:		R/Outpatier		Oth Oth	er: 4 □ Nursing H	ome 5 ☐ Resi	dence	6 ☐ Other (Spe	cify)
n O	ing P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		28b. Time of Injury		28c. Injur Worl	k?	28d. Describe	how injur	ry occurred	
sio	ttend death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be		in. At hor	ne farm str	M eet facto		Yes 2□No	28f Location /	Street ar	nd Number or R	ural Route Number,
Division of Vital Records,	To the Hospital or Attending Physician: The I within E4 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	4 Homicide determined	building, etc	c. (Specify,)				City or To	wn, State	•)	
	n 24 hou	Medical		ysician: To the best on the basis of and manner sta	f examinati								
	To ti Withi To ti com	Š	29b. Signature and title of certifier				2	9c. Licens				ite signed (Mont	
	5		7-	parich		7	2	D	006548	5		1/10/	2009
			30. Name and address of person who		•			. + 0'	לם ייי	O i Proces	Cross of	110	20010
	Sta	te	Barbara Ann Supa. 31. Date filed (Month Pay, Year)	ach, KSM,	MV, ar's Signati	1500 ure_8	rore 1	si bil	en ka.,	suver.	spru	ng, MU	20710
	910		milly 7 to 5	75 H KL S A"7.		55 A	n. n. 11						

Amend 20a-c, 22 per Fh G898 12/7/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #7 State of Maryland Department of Health and Mental Hygiene 2000

			1 - St	r ate gistrar		0.0	210 01 11	iai yiai	Ce	rtifica	ite of i	Death	i di ivic	intal Try	Reg. N		109	38878
	Dharaia		1. Dece		e (First, Midd		١.						2	2. Date of De	eath		V- +	3. Time of Death
	Physici /Medi			_	Same.	s Ba	nks							l i	2	bay 2	Year OOG	5:10 PM
1	Examir					n, give street		,		1	y, Town, o	Location of I	Death		4	c. County	of Death	
-	/					pice/No						11stow					timo	
	Funeral Director				0-6201	6. Sex 1 ☑ M 2			last birthday)	If Und Month		If Under 24 Hours	Hrs. 8	B. Date of Bir (Month, D. Sept 2	rth ay, Yea 1	958	9. Birthp Coun Penn	lace (State or Foreign try) sylvania
	w w		Usual F	Residence o	f Decedent 10b. County	,		10c Cit	ty, Town or Lo	antion							14	Od Jasida City Limite
	farylan fshow	5		1D	Tob. County			100. 011	Balti								'	0d. Inside City Limits 11☑Yes 2☐No
	the Maryla 28a-f sho	Director		reet and Nu	mher				Darti		ip Code	-		Т	100 0	Citizen of V	What Cour	21.
	with 3a or	Ö				A				101. 2	ip Code	01006			Tog. C			tryr
	death wi	Funeral		ital Status		rd Ave	as Deceden	t Ever in U.	.S. 13.	Was Dec	edent of H	21206	n? (Speci	fv Yes or No)-	14. Bac	SA e - Americ	an Indian.
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examination of ithed at		1 🗆	Never Marr	ied 2 ☐ Mai	ried 1	med Forces	No			ecify Cuba 2∏No	ispanic Origir In, Mexican, F Specify:	Puerto Ri	can, etc.)		Blac	k, White, 6	etc.
2-0	2 hor	ted		/C	15. Deceder	nt's Education	-1-1-0		16a. Dece	dent's Us	ual Occup	ation			16b.	Kind of Bu	isiness/Inc	lustry
Maryland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural", aumatic event, the fredical Exa	Completed by	Elem		ondary (0-12)		llege (1-4or	5+)				during most of	f working					
d 2	filed v Hygie	ပို	17. Fatl		(First, Middle,	l ast))		<u>con</u>	itrac	tor	18. Mother's	Name (First Middle		onstr		on
an	id be lental ked o	To Be			A. Banl	,					İ		ancy	John		an Ournain	(6)	
ary	shou ind M i mar umat	F	19a. In	formant's N	ame/Relations	ship (Type. Pr	int)		19b. Mailii	na Addre:	ss (Street a	and Number o				or Town	State Zin	Code)
	alth a alth a 27 is		J	effre	y Banks	s/broth	ner					n Aver					212	
ore	es 1 a of He if item or othe			thod of Dis				20b. F	Place of Dispo	sition (Na	ame of	e)	Date	e	20c.	Location -	City or To	wn, State
Ē	Pag ment ant: I		4 🗆	Donation	· 5 W Other #	3 □ Remov	of from State	Jos F.F	Place of Disponentery, creenestery, o	wn,	JR 12.	/3/20	009	Ba1	timor	e. M	D	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the redical once.		21. Sig	nature of E	ineral Service	Sen and	Div	éctoi	J	Name of Sept	nd Addres	s of Facility Brown, MD	ogrd	655 V	214	0.1 + 4.	2020	Street on Ave.
			23a. Pa	ert . Enter t	he disease, of	complication	s that cause	d the death	n. Do not ent	er the mo	de of dyin	g, such as ca	ardiac or r	espiratory a	arrest,			Approximate
	Physician		Immed	ate Cause	(Final	only one cau		ine. Ancer										Interval Between Onset and Death
	/Medical		resultin	or condition g in death)		d	Due to for as					_						
	Examiner	L	Seguer	tially list co	nditions	b							_					
	ed sit	ine	if any, le	tially list co eading to im Enter Unde Disease or ated events	mediate rlying	Į	Due to (or as	s a consequ	uence of):									
	and and Il-tran	Examiner	that init	ated events in death) I	_ast	C	Due to (or as	a consequ	ience of):									
68760,	icate be executed physician and the burial-transit						340 10 (0) 40	a concequ	201100 017.									
89	ertificate ing phy e as the	Medical				d												
Вох	attendin for use	_	IF FEM 23b. Wa	s decedent	pregnant	23c. If y	es, outcome	of pregna	ncy	7=						23d. Date	e of delive	ry
o.	The law requires that the death certificate be executed ate has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/	1 [he past 12 Yes 2[Unknown		4 [Live birth Pregnant			Other (s	pregnancy specify)					Мог	nth	Day Year
о, С	ires that signed b	by PI	Part II.	ther signif	icant condition	ons contribution	ng to death b	out not resu	ulting in the ur	nderlying	cause give	n in Part I.		23e. Did t	obacco	use contr	ibute to th	e cause of death?
of Vital Records,	w require s been sig should b												_	1 🗆 🕆	Yes 2	2 □ No	3 ☐ Prob	abiy 4 🖸 Unknown
S	e law re has be e 2 sho	plet												24a. Was		24b. V	Vere autor	osy findings available
- B		Completed			/								_	autop perfo 1 □ Ye s	rmed?	l d	rior to con leath? Yes	npletion of cause of
/ita	sician: Th certificate rector, pag	Be (case referi	ed to medical							26. Place of	Death (C			,	103	2 1 1 1 0
_	this all dir	ဥ	10	Yes 2 🗍		Hospita	1 L Inpati		ER/Outpatien		OA Othe	r: 4 🗆 Nursii	ng Home	5 🗌 Resid	dence	6 DOth	er (Specify	jent-huspice
n C	ding F h. After funera	ion:		r of Death atural	5 Pendin	g	. Date of Inju (Month, Da	ury ay, Year)	28b. Time of Injury		28c. Injury Work		280	d. Describe h	how inju	ury occurre	ed	
isic	Attending r death. ector: After by the funer	icat		Accident Suicide	investiç 6	not be	Place of In	At ho	ma form atten	M		′es 2 □ No	001					
Division	tal or Att rs after d al Direct led in by	Certification:	4 🗆	Homicide	determ	ined 20e	building, el	c. (Specify	me, farm, stre	et, factor	у, опісе		281.	City or Tov			er or Rurai	Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Ce (C) on	IBCK OTHY	1 Certifyir 2 Medical	g Physician: Examiner: O an	To the best n the basis of d manner st	of examinat	wledge, death tion and/or inv	occurre vestigatio	d at the tim n, in my op	ne, date and p pinion, death	olace, and occurred	d due to the at the time,	cause(date ar	(s) and ma	nner as st and due to	ated. the cause(s)
	To the within 2 To the comple	M	29b. Sig	nature and	title of certifier	11-			,	29	c. License	number			29d. D	ate signed	(Month, E	Day, Year)
				(1) DIKAJ	upune.	NID					DOC	5746	,5			11/2	27/0	9
			30. Nam	e and addre	ess of person	who complete	d cause of c		4.0	Print)	Suite	? Dior) P	PIELPNI	itni	vn. I	MN	21136
	Stat	e	31. Date	filed (Mont	-		82. Registr				- 1117		1	CISUIS	100	• • • • • • • • • • • • • • • • • • • •	10	
	Registra			-	0000	000	5	1	As to 1	Land.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOYEMBER 30 TOUG Physician/ 5.40 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN BURNIE AMNE ARUNIDE MEDIZAL WASHINGTON AUTIMORE 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. g, Birthplace (State or Foreign **Funeral** Min. Country) 1 M 2 □ F Days 236-72-3494 Director Usual Residence of Decedent 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants I fitem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traunastic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 No denton ΔD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21113 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ed th Construction inisher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Odenton, MD ila 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Maply 4 Donation 5 Other (Specify) 112-10-09 18434 21. Signature of Funeral Service Licen 22. Name and Address of Facility 1333 MIOVC er the disease, recommendations that caused the repart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arre-23a. Pa shock Immediate Cause (Final Physician/ METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗌 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🗹 No မှ ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 5 Pending Matural ☐ Accident Investigation 6 ☐ Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

State Registrar

Benen

29a. Certifier

(Check

only one)

3 29b. Signature and title of certifier

31. Date filed (Month, Day Year)

30. Name and address of person who completed ca

donve

MIS

use of death (Item 23a) (Type, Print)

spital

trar's Signature

117

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in this opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MO

09-09190 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marcus Beasley State of Maryland / Department of Health and Mental Hygiene 2009 38880 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 26, 2009 ea.s 0326 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Ν 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. Date of Birth (MM/DD/YYY 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 6. Sex Country) Months Days Hours Min 36 -31-683 Director 1 VM Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 0c. City, Town or Location 10a. State Yes 2 No hours after death with the Maryland Funeral Director 10f. Zip Code 10g. Citizen of What Country 10e, Street and Number 2121 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Yes 9 Yes. Give Year Yes 2 No specify. Specify Widowed Divorce ۵ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "n marked other than " Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) 20 aslo mnie Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Boyd Annie 30 mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 4 Donation 5 Other Specify 21. Signature of voneral Service Licen 22. Name and Address of Facility complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Heroin and alcohol intoxication ate Cause (Final disease xaminer or andition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical XUNPENDED AMENDED g898 12/10/09 TT ,permE, 3a,27,28a-f 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Ectopic pregnancy Day Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? No ✓ Yes 2 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 FR/Outpatient 3 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Natural 5 Pending 11/26/09 Fd 2:10 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2/31 Pelham Ave Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide Found: private dwelling Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

State 31. Date filed (Month, Day, Year) Registrar

Medical

32. Regiétrar's Signature

O.C.M.E.

November 26, 2009

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38**88**1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kathleen Ann Bankard-Wolcott 2009 P_M December 4:04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Maryland Days June 28 Hours Min 1 M 2 XI Months 216-40-0479 67 Yrs Director 1942 Usual Residence of Decedent shov 10a. State 10b. County inportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Parkville Baltimore 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6679 Wycombe Way 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Medical Supplier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Bankard Unknown 2, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7911 Westmorelane Avenue, Parkville, MD 21234 John McCann / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 12/4/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) Moreland Signature of Funeral Service Lices 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes ∠ ¥ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate h Yes 2 X No Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After in ppleted filled in by the funera 5 Pending X Natural Division 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier

State Registrar

within 2.

To the F

only one) 29b. Signature and

JACKIE JONES,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2009

DECEMBER

KATHLEEN WOLCOTT

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29c. License number

State of Maryland / Department of Health and Mental Hygiene 38882 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 1658 Forestine L. Brown December 1 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 705 Deacon Hill Court Baitimore n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 X F Director 219-40-2912 5/2/1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "national Exercises" and the national and Director 1 X Yes 2 No MD Baltinore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 705 Deacon Hill Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African-American 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event. In Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည James Brown Irene Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kaisha L. Sessones-Mason/Daughter 1007 N. Woodyear Street, Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 12-7-09 Glen Burnie MD 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. ature of Funeral Service Licenses Vin dos 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fînal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner abete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-transit P.O. Box 68760 € Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ğ icate has been si , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 6 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Aftetely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 0052201 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HAMOVER STREET RATIBHA HARMA 001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Department of State of State of State of State of Maryland / Department of State of Sta	ate of Death	Reg. Ne	2009	38883
ŧ.	Physicia	n	Decedent's Name (First, Middle, Last)		Date of Death	2009	3. Time of Death 5:05 P M
	/Medic	al	TOBIA BECHERMAN 4a. Facility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death	ecember 1	c. County of Death	
-	Examin	er	Tall I dollay training (if first manager)	BALTIMORE CITY		N/A	
	Funeral			hs Days Hours Min. 8.	Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign ntry)
3	Director	ŀ	212-44-2382 Usual Residence of Decedent		1/09/1918	3	NJ
	nyland how		10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits 1XXYes 2 □ No
	the Ma 28a-f s ootified	Director	MD N/A BALTIMOR 10e. Street and Number 10f.	Zip Code	10a. C	itizen of What Cou	
	3a or		830 W. 40TH STREET, APT. 653	21211		USA	
	r death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. If Yes,	ecedent of Hispanic Origin? (Specit specity Cuban, Mexican, Puerto Ric	ty Yes or No- can, etc.)	14. Race - Ameri Black, White,	
39	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give 1 □ Ye Year or Dates:	s 2 No Specify:		Specify:	WHITE
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121	within iene. than '	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	EMAKER		OWN HOME	
Maryland 2121	be filed w ntal Hygies ed other th event, the	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maide	en Surname)	
<u> </u>	should be filed and Mental Hygi s marked other umatic event, ti	ို	PHILIP BRESLOW 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add	ROSE ress (Street and Number or Rural F		ADISON or Town State Zi	in Code)
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altimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crematory	(Name of Dat		Location - City or T	own, State
<u>Ħ</u>	Z ∺ e B		4 □ Donation 5 □ Other (Specify) HAR STNAT CO		/2009 OW		
Ba	permit. I Departm Importar any inju		1	REISTERSTOWN RO	LEVINSON DAD. PIKES		
	-10M		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac or i	respiratory arrest,		Approximate Interval Between Donset and Death
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_		Medi	IF FEMALE:		· · · · · ·		
Вох	eath ce attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	pic pregnancy er (specify)		23d. Date of deli Month	very Day Year
<u>Р</u> О	t the di by the ached	hysid	1 Yes 2 No 9 Unknown				
	The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.			the cause of death? bably 4 Unknown
cor	w requ	Completed			24a. Was an	24b. Were au	topsy findings available completion of cause of
Re	The law cate has page 2 :	ошо			autopsy performed? 1 Yes 2 ☑	death?	completion of cause of 2 □ No
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or Vital Records,	Attending Physician; r death. ector: After this certifics by the funeral director, i	은 -	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of	J DOA 4 Mursing Hom	e 5 Residence 3d. Describe how in		cify)
ion	inding ath. ir: Afte ie fune	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M				
Division	or Atterder de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office 28	3f. Location (Street City or Town, Sta		ral Route Number,
_	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occu	urred at the time, date and place, at ation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Comple	Mec	29b. Signature and title of certifier	29c. License number		Date signed (Monti	
			No Toabelle Mas greger 503	D18657	Dec	ember 2,	20009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRABELLE THE GREGIE, \$30 W. 400	th Street, Balque	nesse, ora	221211	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38884 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month December MARK BEREZIN 0711 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15c Baltimore N/A Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 03-17-1929 80 Director 214-23-4388 UKRAINE Usual Residence of Decedent fshov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10d. Inside City Limits Director BALTIMORE 1 🗌 Yes 2 💢 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6976 MILLBROOK PARK DRIVE, #1A 21215 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) प्र Hygiene. I other than ' Elementary/Seconday (0-12) College (1-4 or 5+) SALESPERSON FOOD SERVICE permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MAYER BEREZIN FAIGA BAIGELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6976 MILLBROOK PARK, #1A, BALTIMORE, MD 21215 FANIA BEREZIN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 12-04-2009 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Juneral Service Licen 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 201 Medical resulting in death) Examiner Bowe Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Fctopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law 124 hours after death.
9 Funeral Director: After this certificate has t autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 욘 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier 1 Scriffying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat

Registrar

State

Bobby Burches, Jr.

(Month, Day, Year)

31. Date filed

Hospitul

eted cause of death (Item 23a) (Type, Print)

Sinai

32. Registrar's Signature

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RES DOO

of Baltimere 2401 W. Belvedere Dr. Baltimere, My 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 38885 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 December George Harold Baker, Jr. 1:15p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bel Air Harford 128 W. Ring Factory Rd Apt. 1221 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Yea April 25, Funeral 9. Birthplace (State or Foreign **★**★M 2 □ F Months Days Hours Min. Maryland Director 222-05-1573 1921 Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2 No Harford BelAir <u>Maryland</u> 10e. Street and Number 10g. Citizen of What Country? Funeral 128 W. Ring Factory Rd. Apt. 1221 21014 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 Black White etc. 1 Never Married 2 Married 1X Yes 2 No If Yes, Give 1942–46 Year or Dates. þ Maryland 21215-0036 1 Yes XX No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mes Elementary/Seconday (0-12) College (1-4 or 5+) civil service US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George H. Baker, Sr. Lockhart Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty F. Baker (wife) 128 W. Ring Factory Rd. Apt. 1221, BelAir, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Baker 12/7/09 Cemetery Aberdeen, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility Tarring_Cargo Funeral Home, P.A. Maryland 21001 Aberdeen, 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death METASTATIC BLADDER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant 9 Unknown Pregnant at time of death Day detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSIDA Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗀 No 1 Yes Vital Physician: completed filled in by the funeral dire tor, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA this of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 \square Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Corrilying Nurse Practioner 10 the last of my included a cast account of the time, date and place and Secretary and one stated (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Ablu

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTH AVE

09-09402	
Wayne Collins	

15406

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

ayne Collins		State of Maryland / Department of Health and Iviental Hygiene - For State Certificate of Death Reg. No. 2009 388
Physiciar ledical Examin	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day December 2, 2009 3. Time of Death 2134 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital 4c. County of Death N/A
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Min. 12 - 09 - 1956 Country) 7. Age (In yrs. last birthday) The foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthd
215-0036 be filed within 72 hours after death with mtal Hygiene. Red other than "natural", or items 23, etc., the Maik al Examiner must be no	To Be Completed by Funeral Director	Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. State 10b. County 10d. Inside City Limits 10d. Inside Ci
Physician Results of the second seco	1	22. Name and Address of Facility 270 And A filter for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Upper gastrointestinal hemorrhage Due to (or as a consequence of):
	iner	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Course
ted	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
60, tte be executed hysician and e burial - transit	Medical	X UNPENDED X AMENDED 23a, P11, 27, permE, g900 2/3/10 TT Ttem#5perFH, C898, 12/7/09, WS
687 certifice nding p	- 1	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. Bost that the deat		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ords, F aw requires has been sign 2 should be	Completed by	of the liver of the liver of the liver of the liver of the liver of the liver of the liver of the liver
tal Re(ian: The certificate ector, page		25. Was case referred to medical 26. Place of Death (Check only one)
F Vita Physicia or this ce	To Be	examiner? 1 Ves 2 No 27. Manner of Death A Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
on of ending Pl ath. or: After the funera		1 X Natural 5 Pending (Month, Day, Year)
Division of Vital Rec pital or Attending Physician: The ours after death. reral Director: After this certificate filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
£ % £ 3	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 3, 2009
		30. Name and address of person who completed cause of death (Item 23a)
		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature
St Regist	ate rar	OFC 0 7 2009 Janua A. Barrol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09158 State of Maryland / Department of Health and Mental Hygiene Shannon Lavar Colbert 2009 38887 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 24, 2009 1930 hrs Medical Examiner Shannon Lavar Colbert 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) July Jult Months Days Min Hours Director 219-90-1356 32 26,197 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1x Yes 2 No or 28a-f show MD n/a Baltimore notified at once. hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 1010 Abbott Ct. 21202 USA or items 23a 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 Was Decedent Ever in U.S. or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify: Black Yes 2 X No specify: If Yes Give Yes Divorce Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. nut: If item 27 is marked other than "natural", à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) MD 21215-0036 Security Guard unknown llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Colbert, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tonya Davis (sister) Plymouth Rd. Balto, Md 5103 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Saltimore. crematory or other place) 09 Dec. Burial 2 X Cremation 3 Important; injury or oth GreenMount Crematory Baltimore, Md Donation 5 Other Specify nature of Funeral Service Licens Scruggs Funeral Home re death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard 23a. Part I. Enter the disease, or complications that cause **Physician** Between Onset and Complications of gunshot wounds to abdomen right forearm failure. List only one cause on each line. /Medical Death a. and Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 23a,27,28a-f,permE, G898 12/9/09 TT Physician/Medical X AMENDED #8 per Fh g898 12/7/09 TT tending physician a use as the burial -X UNPENDED Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown neate has been signed by the a page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? <u>о</u>. contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes certificate Yes 2 Nο 26.Place of Death (Check only one) 25. Was case referred to medical director of Vital Be Other4 examiner? Nursing Home 5 Residence 6 Inpatient 2 ✓ ER/Outpatient 3 this 1 ✓ Yes ۵ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury subject shot 1 Natural Yes 2 X No Division n 24 hours after death.

e Funeral Director: A letely filled in by the fu Pending 8/14/08 1212 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) (Specify) street determined 1400 E. Preston St Baltimore, 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 26, 2009 O.C.M.E

State Registrar

> DHMH 17 Rev 1/2001 OCME 2006

arte

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year,

Assistant Medical Examiner

			1 - For State Registrar	110000	State of M		/ Depa		f Heal	th and N		ygien Reg. Ne	_		38888
	Physician /Medical		1. Decedent's Name ((First, Middle, Las							2. Date of Death Month			ear	3. Time of Death
man leg			4a. Facility Name (If n	not institution, give	H.	-)		4b. City, Town	.ggs	tion of Death	Decemb		, 200 c. County of	_	4:48 AM
	Examir	ier	Union Me		sareer and number	/		Balti				- 1	/A	Death	
	Funeral		5. Social Security Num	nber 6. Se		ge (In yrs. last	birthday)	If Under 1 Ye	ar If Ur	nder 24 Hrs.	8. Date of B		9	. Birthp	lace (State or Foreign
	Director	П	217-26-9	693	X M 2□F	86	Yrs.	Months Da	ys Hou	urs Min.	03/16	/19:	23 I	V.C	arolina
	pu ≥		Usual Residence of D	ecedent 0b. County		100 City T		ation						14	0d. Inside City Limits
	arylan show ed at	5	7	•		10c. City, T								1	1 Yes 2 No
	the M 28a-f lotifie	Director	MD 10e. Street and Numb	N/A	<u> </u>	Bal	timor	10f. Zip Cod				10a C	itizen of Wh	at Cour	
	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show I'm Modre I Exminer must be notified at		1722 Hol		7+moot				。 1202	2		U.S		at Oouri	ili y .
	ns 23 mus	Funeral	11. Marital Status	. AOOIG.	12. Was Decedent	t Ever in U.S.	13. W				ecify Yes or No Rican, etc.)		14. Race -	Americ	an Indian,
9	or iter		1 Never Married	2 Married	Armed Forces 1 X Yes 2 □	? No					Rican, etc.)			White, e	etc.
03	ours a	<u>5</u>	3 ∰Widowed 4	□ Divorced	If Yes, Give Year or Dates:		1	∐Yes 2 🔀	No <i>Sp</i> e	ecify:			Specify:	3la	ck
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2	be filed htal Hyg ed other event, I	ပိ	4th Grad				sugar	Drum			e (First, Middl			Sug	ar CO.
auc		Be	17. Fallers Name (77		20112				10.10			o, marco	n ourname,		
Maryland 21215-0036	d 2 should th and Mer 7 Is marke traumatic	မ	19a. Informant's Nam		nown	1.	19h Mailine	Address (Str	Lucy Street and Number or Rural Route Number, City or Town				or Town St	vn. State. Zio Code)	
	alth ar 27 Is r trau		Carolyn 1				-	,					,		21202
ē	s 1 and 2 of Health of item 27 is other tra		20a. Method of Dispos	sition		20b. Plac		ition (Name of atory or other			Date	_	ocation - Ci		
Ē	e = 5			Cremation 3 ☐ ☐Other (Specify	Removal from State)	; _		d Cem.	Siace)	12/1	0109	Ba	ltimo	re.	. MD
Baltimore,	permit. Pag Departmen Important: any injury once.		21. Signature of Fune			1141			dress of E	acility STOWN	Jr. F				
Ω.	8 3 E 8 8		MA		1.10	W	21	40 N.	Ful	ton A	ve.,	Bal	timor	e,N	ÍD 21217
	Physician		Immediate Cause (Fi	failure. List only o	lications that cause one cause on each	d the death. I	Do not ente	r the mode of	dying, suc	h as cardiac	or respiratory	arrest,		2	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due o (or as	a consequen	ce of):								
	Examiner	<u>.</u>	Sequentially list condi	itions,	b. pnew	monus s a consequen	2							0	24 MOURS
N/	nsit	Examiner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inj that initiated events	ce of):	rt fa	ilun	9					24 hours ten years			
BX.	te be executed /sician and e burial-transit	xar	that initiated events resulting in death) Las	st	C. Due to (er/as	a consequen	ce of):	ţ. y -v.			-			- 7	ery curs
160	e be rsicial s buri	cal			a Atrial	Fibr	illatio	'n							
					u		. , , , , ,						7-20		
.O. Box	Attending Physician: The law requires that the death certificate be executed refeath. refeath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 N 9 Unknown	onths?	23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown	2 Fetal de	ath 3 🗌	Ectopic pregn Other (specify					23d. Date of Month		ery Day Year
σ.	s that the ned by detacl	Y P	Part II. Other significa	ant conditions co	ontributing to death	but not resultin	g in the und	derlying cause	given in P	Part I.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
rds	quires en sig uld be	d b	Demention	a, Pa	rkinson	's Dis	ease	•			1	Yes 2	2 No 3	☐ Prob	ably 4 🗌 Unknown
တ္တ	law requires t las been signe 2 should be o	olete		•							24a. Wa		24b. We	re auto	psy findings available
æ	The lav te has age 2 :	E									per	opsy formed?	dea	ath?	mpletion of cause of 2 □ No
ital	lan: ''rtifica	Be C	25. Was case referred	to medical					26. F	Place of Deat	1 ☐ Yes h (Check only		0 1	1162	2 🗆 🖽
>	nysic nis ce direc		examiner? 1 ☐ Yes 2 No	, [Hospital: 1 Inpat	ient 2 🗆 ER	/Outpatient	3 □ DOA	Other: 4 [☐ Nursing Ho	ome 5 ☐ Re	sidence	6 □ Other	(Specif	y)
0	ng Pl	ii.	27. Manner of Death	5 Pending	28a. Date of Inj (Month, D	ury 28	b. Time of Injury	28c. li	njury at Vork?		28d. Describe	how inju	ıry occurred		
Sio	tendi eath. or: A the fu	cati	2 Accident	investigation 6 □ Could not be				-	□Yes	2 □No					
=	l or Att after de Direct	Certification: To	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, farm, stree	et, factory, offic	ce		28f. Location City or To	(Street a own, Stat	ind Number te)	or Rura	l Route Number,
7	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical Ce	29a. Certifier 1 (Check only 2 one)	Certifylng Phy Medical Exam	/sician: To the besiner: On the basis and manner s	of examination	dge, death and/or inve	occurred at th	e time, da ny opinion	te and place, , death occur	and due to th	e cause(e, date ar	s) and mani nd place, an	ner as s d due to	tated. the cause(s)
1	To the within 2 To the сотрые	Me	29b. Signature and titl						ense numl			29d. D	ate signed (Month,	Day, Year)
			(Liebal	20-01				4. 70	1U2	29412		0	,	1	11.20

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carnerne D. Pollock, MD 2018 C

31. Date filed (Month, Day, Year)

DEC 07 2009

33. Registrar's Signature

31. Date filed (Month, Day, Year) 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2.20 pm Physician December James Louis Dalton Jr. 2009 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale Square RankLin oital Center 8. Date of Birth (Month, Day, Year) Jan.18, 1944 Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 🖾 M 2 🗆 F 65 Maryland 215 40 9804 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fraction Examinar must be notified at 1 ☐ Yes 2 🔀 No Jackson Director Butts Georgia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30233 USA 247 Stark Rd. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 No
If Yes, Give 1962/64
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Maryland 21215-0036 Specify: White Be Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Martina Broda Health and Menta tem 27 Is marked James Louis Dalton Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9607 Richmond Rd. Warsaw, Virginia 22572 James Louis Dalton III (Son) permit. Pages 1 and De artment of Healt Important: If Item 2 any injury or other once. Baltimoré, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory Inc. 12/8/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death fall 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final cancer **Physician** COLON disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner leuraL e fusion du Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Physician/Medical Examiner requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Hlnknown g 🗌 Unknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 1NO 1 ☐ Yes 2 No 1 ☐ Yes certificate or Attending Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident eral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. hours To the Funeral 29a. Certifier Medical (Check only within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 05, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Baltimore HD 21237 euna FRANKLIN

State Registrar KamLun

31. Date filed (Month, Day,

Year!

32. Registrar's Signature

			For State Registrar	State of Maryland		rtment of H		•	giene 20	09 38	890
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time o	of Death
	Physici /Medio		ELMER			Drane		Month 12		Year 05:3	9 M
-	Examir		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County o	of Death	1
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	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. la	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		 Birthplace (State Country) 	or Foreign
	Director		218-18-0438	84	Yrs.			2/14/19	925	Maryland	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation	-			10d. Inside C	City Limits
	Mary f sh	ţō	Maryland Baltimo	Mi de	dle Ri					1 □ Yes	2 X No
	the 128a	Director	10e. Street and Number	te Mide	те кт	10f. Zip Code			10g. Citizen of Wi	hat Country?	
	3a o		32 Dihedral Drive			21220			U. S. A.		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,	
9	after or ite		1 ☐ Never Married 2 ☐ Married	1 Yes 2 □ No		Yes 211 No	Specify:	nicali, etc.)		, White, etc.	
003	72 hours after death with the Maryland hatural", or items 23a or 28a-f show diest Examirer must be redified at	d by	3 X Widowed 4 □ Divorced	Year or Dates: WWII			орсону.		Specify:	White	
5-	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of work	ing	16b. Kind of Bus	siness/Industry	
12	within sne.	E G	Elementary/Secondary (0-12)	College (1-4or 5+)					Milita		
d 2	filed \ Hygid ther		17. Father's Name (First, Middle, Last)		Mater	ials Cood	18. Mother's Name	e (First, Middle,	Militan Maiden Surname		
an	d be f ental ced o	Be c							_	,	
Maryland 21215-0036	2 should be filed within 72 hours after death w and Mental Hygiene. Is marked other than "natural", or items 23a aumatic event, the Medical Examirer must	ဥ	Elmer Drane 19a. Informant's Name/Relationship (7)	voe. Print)	19b. Mailin	g Address (Street a	Catheria and Number or Bur		Jrner er, City or Town, S	State, Zip Code)	
S	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Profice Exyrciter must be confined at		Norma Jean Moxe	-	_	ider Driv			, Marylar		
ē,	s 1 ar if Hez item othe	1	20a. Method of Disposition			sition (Name of natory or other place		Date		City or Town, State	
e E	Page ent o nt: If		Wall Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	inetery, crem	Momoria	l Chrdon	12/7	Middlo I	River, Mar	arland.
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21. Signature of Funeral Service Licen	see	22	. Name and Addres	ss of Facility	2009	rituate i	XIVEL, MAI	.yrand
m	Physician Physician		Mardail C. a	Tallian Sr.	₽	ruzdzinsk	i Funera	l Home I	PA Essex. Ma	aryland 21	221
			23a. Part 1. Enter the disease, or comp	olications that caused the death						Approxima Interval Be	
J. Line		0.1	Immediate Cause (Final disease or condition	a. Hepatic	L					Onset and	Death
	/Medical		resulting in death)	a. Due to or as a consequ	ence of):	art					
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	pa #	ine	Sequentially list conditions, if any, leading to transdict cause. Enter Underlying Cause (Disease or injury	Clie fo (or as a consequ	enne offe	,				Î	, -
1170.	and -trans	Examiner	that initiated events resulting in death) Last	anna aft.							
8760,	cate be executed oblysician and the burial-transit	ᇤ		Due to (or as a consequ	ence or).						
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Box (certil nding Ise as	Me.	IF FEMALE:	23c. If yes, outcome of pregnar	тсу				23d Date	e of delivery	
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O.	the or	Physician/Me	9 Unknown	9 Unknown		,,,,,,,					
о, О,	s that ned b	by P	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contri	bute to the cause of	death?
ğ	The law requires that the death certifin ate has been signed by the attending page 2 should be detached for use as							1 🗆 1	Yes 2 □ No	3 ☐ Probably 4 🗹	Unknown
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ū	ding Phys J. After this funeral di	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work		28d. Describe h	now injury occurre	:d	
sio	tend leath tor; / the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □No	201 1 11			
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	pital		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	vledge death	occurred at the tin	ne date and place	and due to the		nner as stated	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p. completely filled in by the funeral director, page 2 should be detached for use as	edical		niner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and place, a	.nd due to the cause((s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, Day, Year)	
			the state of	MD		P27	3112		12.04	- 2009	
	10+1		30. Name and address of person who		23a) (Type,	Print)				- 2009 D Z1201	
	6.		Jasa Sny	JET MO	22 5	Greene	St I	Baltim	ONY, W	0 21201	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra s Signat	BARCO						
	riogiali	· .	TEL U 6 EGGG	0 00							

			101	Department of Health and Me Certificate of Death	ental Hygien	е			
				Reg. N	·2009 38891				
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month Date	ay Year 3. Time of Death			
	/Medic		ELWOOD E. 10RD		DECEMBER				
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death			
	<u> </u>		JOHNS HOPKINS BRAVIEW MEDICAL CENTE 5. Social Security Number 6. Sex 7. Age (In yrs. last bir.		8. Date of Birth	9. Birthplace (State or Foreign			
н	Funeral Director			Yrs. Months Days Hours Min.	(Month, Day, Year 5-29-1913	Country)			
	n or regan		Usual Residence of Decedent		0 27 ()/ -	3 MARY/AND			
	rylan how at		10a. State 10b. County 10c. City, Towr	n or Location	_	10d. Inside Cify Limits			
	e Ma-fs	당	MARYLAND	BAITIMORE		1, Yes 2 No			
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?			
	ath w	<u>a</u>	3505 R. BAHIMORE St.	21224		US-A.			
	tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc. 			
36	72 hours after death with the Maryland hatural", or items 23a or 23a-f show dical Examiner must be notifled at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐No Specify:		Specify: inhite			
5-0036	2 hou atura cal E	ed	15. Decedent's Education 16a.	Decedent's Usual Occupation	16b. I	Kind of Business/Industry			
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212	d within giene. er than " the Mec	ĕ	12	Electrician		HITTEN HOTEL			
P	al Hy other vent,	Be	17. Father's Name (First, Middle, Last)	•	(First, Middle, Maide	n Surname)			
<u>/la</u>	Mental Mental arked carlic ever	2	FRANK FORD	unika	rown				
Maryland	2 sho and is ma			Mailing Address (Street and Number or Rural					
_	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			3505 E. BAIL	· More It	· Ballo Md Z1224			
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	Disposition (Name of Day, crematory or other place)	ate 20c. l	Location - City or Town, State			
ţi	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specify)	HILL Men. GARDINS 12-1	0-09 0	Altinor MARY/AND			
Bal	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		21. Signature of Funeral Service Licensee	HILL Men. GARDWS: 12-1 22. Name and Address of Facility Jo.	SUPL N.Z	ZANNINO JR.F.H.			
			23a. Part1. Enter the disease or complications that caused the death. Do n	100 5. CONKING	3T. DI	Approximate Approximate			
		V 10	shock, or hear failure. Ist only one cause on each line.		respiratory arrest,	Interval Between Onset and Death			
*	Physician /Medical Examiner		disease or condition resulting in death)			ZS YEARS			
			Due to (or as a consequence of the PERTENSION	on):		25 YEARS			
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	uted d ansit	Examiner	rarry, leading to himisulate cause. Enter Underlying Cause (Disease or injury that initiated events						
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8760,	icate be executed physician and s the burial-transit	dical	d						
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Box	death certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3□Ectopic pregnancy		23d. Date of delivery Month Day Year			
0	The law requires that the death certific are has been signed by the attending page 2 should be detached for use as	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day Tear			
<u>α</u>	res that the de signed by the a be detached to		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobacco	use contribute to the cause of death?			
Records,	signe d be	Completed by	and the second s	SEASE CONGESTIVE	1 ☐ Yes	,			
Sor	w require been signated should b	etec	HEART FAILINGE	33,30,30,30,30	040 1110	045 144			
Re	he lav e has	du	HEART PAILURE		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
ta	siclan; The certificate ha		25. Was case referred to medical	OC Diseased Death	1□ Yes 2☑N	lo 1 Yes 2 No			
or Vital	8 55	To Be	examiner?	26. Place of Death patient 3 DOA Other: 4 Nursing Hom		6 □Other (Specify)			
			27. Manner of Death 28a. Date of Injury 28b. T		8d. Describe how inju				
io	Attending r death. ector: After by the fune	atio	2 ☐ Accident investigation	M 1 Yes 2 No					
Division	- 0 <u>-</u>	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)			
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7	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.						
(1)	ro the vithin 2 го the сотрые	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)			
	⊢ ≯ ⊢ ŏ		Day landle Ma MAT						
			30. Name and address of person who completed cause of death (Item 23a) () 062032 Type Print)	1060	EMBER 3 2009			
			JENNIFER HAVASHT 5505 HODELN	C DAVITER GEDGER	RAI TIMO	DE MD 21224			
	Sta	te	31. Date filed (Month, Day, Year) 2009 33. Registrar's Signature	park CIRCLE	DALITIMO.	RE,MD 21224			
	Registr	ar	MEN O 1 5000 Joseph 7. 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#20a, perFH, G898, 12/7/09, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2009 38892 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER **JEROME** S FREEDMAN 2009 12:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year **Funeral** 6. Sex, 1 **M** M 2 □ F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) NY Hours 0671471924 100-14-8378 85 Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Examiner must be notified 1 X Yes 2 ☐ No MD N/A BALTIMORE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 830 WEST 40TH STREET, #616 21211 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced Completed Specify: Year or Dates WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) COURT REPORTER NEW YORK COURTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BARNETT FREEDMAN JEAN FRANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY FREEDMAN / WIFE 830 WEST 40TH STREET, #616, BALTIMORE, MD 21211 20a. Method of Disposition

Takeurial 2 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) CARROLL CREMATION INC 12/4/2009 HAMPSTEAD, MD f Funeral Service 22. Name and Address of Facility Vicer SOL LEVINSON & BROS., ROAD PIKESVILLE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Qnset and Death** Ph sician/ SIJ disease or condition resulting in death) Medical Due to (or as a sinsequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical attending physiciar P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 🗌 No Yes 2 No 1 Tes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009

State

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NES

W

32. Registrar's Signature

MAR

29b. Signal

MORA

31. Date filed (Month, Pay Year)

6701

09-09301 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Lashawn Danielle Hunter 1. For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1335 hrs Medical Examiner November 30, 2009 Danielle Hunter LaShawn 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** N/A 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8 Date of Birth (MM/DD/YYY) 7. Age (In vrs. last birthday) **Funeral** 6 Sex Country) 218-06-3305 Months Days Hours Min Director 08/23/1984 2 X F м 25 Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County Oc. City, Town or Location any 1 X Yes 2 No 28a-f show items 23a or 28a-f shorust be notified at once. MD N/A Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10q. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 2434 W. Franklin Street 21223 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. other traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No 0 Yes, Give Yea Yes 2 X No specify: Specify: Black Widowed Divorced marked other than "natural", ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Allied Barton Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12th Grade Security Guard Security Service 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor Deborah Hunter Stephen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ mportant: If item 27 is Balto., MD 21223 Franklin Street, 2434 W. Emma Hunter(Grandmother) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 12/05/09 Baltimore, MD Woodlawn Cemetery Donation 5 Other Specify: ²² Name and Address of Facility Joseph H. Brown Jr. Funeral Home 21. Signature of Funeral Service Licenses 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): n and transit Physician/Medical X AMENDED UNPENDED signed by the attending physician be detached for use as the burial G898 12/7/09 TT 19a, per Fh Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been s I director, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No ✓ Yes No Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) funeral director, 25. Was case referred to medica Be examiner? Other₄ Hospital: 2 ER/Outpatient Nursing Home 5 DOA Residence 6 Other Inpatient No ٩ 1 🗸 Yes After Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: Nov 30, 2009 Passenger auto collision 1306 hrs Natural Yes 2 ✔ No Pending Funeral Director: stely filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 5000 block of Wabash Avenue , Baltimore, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 1, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

BURGA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 38894 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1416 Physician/ Month Year TARGARE! $a^{\,\mathsf{M}}$ 3:11 November 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
April 13, 1929 5. Social Security Number 9. Birthplace (State or Foreign Country) **Tennessee** 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗷 F 408-36-2155 80 Director Usual Residence of Decedent 28a-f show 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Glen Burnie Maryland Anne Arundel 1 Yes 2 No P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21060 U.S.A. 1038 6th Street than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗷 No Specify: White 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with n and Mental Hygien ris marked other ti Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Collins . John W. Rosa N. Wr L-CHI permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carman E. Hill 1038 6th Street, Glen Burnie, Maryland 21060 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cedar Hill Cemetery Dec. 04, 2009 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 21. Signature of F all Service Licen art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' certificate 2 No Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Bégistrar's Signature

		For State Registrar	se Type or Prind #150areform	Tryland 6	898al	indie ink. 2/19/09 ficate of L	leath and I	Mental Hy	giene	009	38895
Physicia /Medic		1. Decedent's Name (First, Middle Patrick K. Ha						2. Date of Dea Month Nov.		20°0′9	3. Time of Death
Examin		4a. Facility Name (If not institution Union Hospita		b. City, Town, or Elkton	Location of Death	ı	4c. County of Death Cecil				
Funeral Director		5. Social Security Number 223-10-7948	6. Sex 7. Ag	e (In yrs. last b 91		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Apr. 9	Yea <i>r)</i> 1918	9. Birth Con VA	hplace (State or Foreign untry)
Maryland f show	Funeral Director	Usual Residence of Decedent 10a. State TN MD Ceci	1	10c. City, Tov			ng Sun				10d. Inside City Limits
3a or 28a		10e. Street and Number	ue 1728 Bigg	gs HWY		10f. Zip Code	21911		10g. Citizer	n of What Cou	ıntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitival Let rottled at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1★Yes 2□1 If Yes, Give Year or Dates:		If Y	s Decedent of Hi es, specify Cuba Yes 2 XNo	ispanic Orlgin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		. Race - Amer Black, White pecify: Whi	, etc.
within 72 hc ene. than "natur he Modical	To Be Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5		(Give kir life. DO	nt's Usual Occupa ad of work done of NOT use retired Laborer	luring most of wor)	king		of Business/I	
uld be filed Mental Hygi irked other itic event, I		17. Father's Name (First, Middle, unk.)	Last)					ne (First, Middle, Bollir	Maiden Su		•
and 2 sho salth and I of 27 is ma er traums		19a. Informant's Name/Relations Jimmy Kyle Ha	, , , ,				and Number or Ru				ip Code)
Pages 1 and the ment of He ment of He mut: If item and ary or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			ison	on (Name of fory or other place Forest)wing		ls,M D
permit. Departr Importa any inju		21. Signature of Funeral Service	Licensee /	ands			ss of Facility We: Cern Ave				
Physician	Examiner	23a. Part 1. Enter the disease, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. ASPIRATION PNEUMONIA.									
/Medical Examiner		resulting in death) Sequentially list conditions.	b. SMA		NEL		RUCTIO	,			
te be executed /sician and e burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	с	a consequence							
death certificate be attending physical for use as the b	Medical	IF FEMALE:	d								
the death ce by the attend ached for use	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal deat		ctopic pregnancy	(230	d. Date of deli Month	ivery Day Year
uires that n signed b Id be deta		Part II. Other significant condition	ons contributing to death b	ut not resulting	in the unde	erlying cause give	en in Part I.				the cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the laws.		Chronic Re	nal Insu	fficie	ency						topsy findings available completion of cause of
sician: certificienti	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	ar.	th (Check only o			
nding Physician: The lath. sth. r: After this certificate he funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig		ry 28b.	Outpatient Time of Injury	28c. Injun Work		lome 5 Resid			ify)
tal or Atte s after de al Directo ed in by th	Certific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		farm, street	reet, factory, office 28f. Location (S City or Tow				Street and Number or Rural Route Number, vn, State)		
he Hospit in 24 hour he Funera pletely fills	Medical	29a. Certifier 1 ☐ Certifyin (Check only one)	g Physician: To the best Examiner: On the basis o and manner sta	f examination a	ge, death o and/or inves	ccurred at the tin stigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) ai date and pl	nd manner as lace, and due	stated. to the cause(s)
Not Not Not Not Not Not Not Not Not Not	Σ	29b. Signature and title of certifier	7.			29c. License	number		29d. Date s	signed (Month	ı, Day, Year)
		30. Name and address of person	M-D who completed cause of d	eath (Item 23a)	ı) (Type. Pri	1 D 6	9181		11	30/20	000
		TAHMAY SI					ELICTO	m, mD	210	12/	
Stat Registra		31. Date filed (Month, Day, Year)	2009 32/Registr	ar's Signature	par	Kel				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8,20b,c,perFH,G898,12/17/09,WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 1:52 **Physician** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner of Maryland Baltimore Medical Center 8. Date of Birtt2-12-1960 9. Birthplace (State or Foreign (Month, Day, Year)

Dec 12-1960 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **№** M 2□ F 219-70-2501 49 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Wedeal Examiner rust be routified at 1√2 Yes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1009 N. Broadway, Apt. B 21205 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Balck þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Stock Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Wallace Hill, Sr. Denoso Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1009 N. Broadway, Apt. B, Baltimore, MD 21205 Monica L. Hill 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemeter

Mt. Carmel 20c. Location - City or Town, State Date 20a. Method of Disposition 12-12-09 Dundalk, MD Landsdowne, MD Department of Important; If it any Injury or c tx Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of FacilityWesley Chavis, Jr. permit. 21. Signature of Funeral Service Licensee Wesl 2007 Eastern Ave. Baltimore, MD 21231 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final endocarditis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ☐ Pregnant at time of death 5 Other (specify) s been signed by the should be detached 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 4 Unknown arter disease 1 🗌 Yes 2 No 3 Probably coronar Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Stag 24a. Was an certificate has page 2 autopsy performed Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director: A death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) labatahai 21201 S. Greene St MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

09-09379

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hvoiene

eland Derrelle I	i	I- For State Certificate		Reg. N	
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month December 2,	y Year 0013 hrs
rearear Exami		Leland Derrelle Hunt 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		2409 Southern Avenue	Temple Hills	To the state of	Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1244–25–6539 1 M 2 F 32) If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NC
v any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.			10d. Inside City Limits 1 Yes 2 X No
daryland 28a-f show	ē	MD Prince Georges Suitla	10f. Zip Code	10a. 0	Citizen of What Country?
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nours a	ed by	durii	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use re		b. Kind of Business/Industry
5-0036 led within 72 hours tygiene. other than "natur	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Sel	f employed	1	Entrepreneur
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	ပေ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	ten Surname)
2121 Ild be fi Mental marked event,	o Be	Martin Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. M	Yael Hunt ailing Address (Street and Number or	Rural Route Number	r, City or Town, State, Zip Code)
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Menhal Hygi Important: If liten 27 is marked ohin injury or other traumatic event, the 1		Yael Hunt Whitfield/Mother 22	280 Yorville court, Occ	ee. FL 3476	1
r re, l s 1 and if Healt if item			sposition (Name of cemetery, or other place)		Oc. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hes Important; If ite		4 Donation 5 Other Specify: Simon Te	mple Cemetery 12-	10-05 1	ayettville, NC
Ball permit Depar Impor injury	W S	21. St. After of Funeral Serves Ucensee	9200 Liberty Road, Rai		ome PA. of Baltimore Co. Md 21133
Physician	1	253 Part I. Enter the disease or complications that caused the death. Do not en failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Interval Between Onset and
/Medical *xaminer		Immediate Cause (Final disease a. Gunshot Wound of Head			Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	niner	if any, leading to immediate Due to (or as a consequence of):			
.√k·₽ ig	Physician/Medical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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Box 687 c death certifics the attending pode for use as the	cian	past 12 months? past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic preg Other (Specify)	nancy	World Day real
O.O. BO) that the death ned by the att detached for	hysi	1 Yes 2 No 9 Unknown 9 Unknown	the control of the co	23e Did toha	acco use contribute to the cause of death?
P.O. es that the gened by e detach	ক্র	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		2 No 3 Probably 4 Unknown
Records, P The law requires the ficate has been signary, page 2 should be d	Completed			24a. Was an autopsy	
ecor he law te has b	ᇤ			performe	ed? death?
tal Recidant The	Be C	25. Was case referred to medical examiner?	26.Place of Death (Chec		
of Vital Records, P.O. ng Physician: The law requires that the forthird this certificate has been signed by meral director, page 2 should be detact	일	1 ✓ Yes 2 No Inpatient 2 ER/Outp	atient 3 DOA Other Number of Injury 28c. Injury at Work?	sing Home 5 Re	esidence 6 🗸 Other: Scene w injury occurred
Sion of Vital I Attending Physician: r death. ector: After this certifi by the funeral director,	<u>i</u>	1 Natural 5 Pending Pec 1, 2009 Year) 2356 h		Subject shot	
Division tall or Attendil rs after death.	ificat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	or Town, Stat	reet and Number or Rural Route Number, City
Divi spital or nours afte neral Dir	Certification:	4 Homicide determined (Specify) Parking Lot		2409 Southern	Avenue , Temple Hills, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Čertifier 1 Certifying Physician: To the best of my knowledge, death (Check only) Wedical Examiner: On the basis of examination and/or inverse.	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cause(d at the time, date an	s) and manner as stated. Indicate, and due to the cause(s)
To To	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		high, v.s	O.C.M.E.		December 2, 2009
K		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21201		7
	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature			
Regi	strar	DEC 0 7 2009 Burns & park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 Physician/ Wilbur Raynor James Month 2009 4:00 Novembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1422 Gorsuch Avenue N/ABaltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 29, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Hours Min. 213-32-4145 72 Director Marvland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director MD N/ABaltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1422 Gorsuch Avenue 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meaonee. 12th Grade College (1-4 or 5+) Steel Worker Bethlehem Steel Be 18. Mother's Name (First, Middle, Maiden Su. Othella Williams 17. Father's Name (First, Middle, Last) Maiden Surname) Roscoe James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orangee James/ Wife 1422 Gorsuch Avenue Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 2 / 4 / 0 9 Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Vet. Cem. Owings Mills, 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death

2 years Immediate Cause (Final Physician/ Prostate Metastatio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician. The law requires that the death certificate be executed burial-transi the attending physician and hed for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of the control of the cont IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown detached 9 Unknown has been signed by le 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Completed 0660000 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an recipheral Vasculas autopsy performed certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: 4 \(\sum \) Nursing Home 5 \(\overline{ 2 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

^{Year)} 2009 31. Date filed (Month State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

An Mony

only one) 29b. Signature and title of certifier

2. Registrar's Signature

Watkins, M.D.

Watkins

29c. License number

D0063657

St. Ste. 136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 29, November 2009 7:31 a Helen М. Januszeski 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Y April 6, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 👿 F Months Hours Min. Maryland 216-09-2879 92 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Timonium 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21093 2300 Dulaney Valley Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X ☐ No Specify White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Kruszelnitski Katherine not known 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Carreras-daughter 4063 Tarpon La., Woodbridge, VA 22193 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Timonium, MD 12/7/09 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility William G. Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are ach line. Immediate Cause (Final disease or condition resulting in death) as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 mon 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

physician and

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signed by

certificate has

After this

after death

within 24 hours a

To the Funeral I

The law requires

or Attending Physician:

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Physician

/Medical

Examiner

Directo

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Completed

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Funeral

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventhal remained at once.

Baltimore, Maryland 21215-0036

2009

Box 68760,

Ö

Division of Vital Records,

JANUSZESKI

HELEN

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical

9 Unknown

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? Yes 2.23No 1 □ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Completed 25. Was case referred to medical Be examiner? 1 Yes 2 No Certification: To 27. Manner of Death Natural 5 ☐ Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TIMONIUM, MD 21093

(Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature-and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY ROAD 32. Registrar's Signature

State Registrar

Medical

0

09-09268 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Clarence Jones State of Maryland / Department of Health and Mental Hygiene 2009 38901 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Clarence Morris Jones Month November 29, 2009 1208 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2457 Seamon Avenue Baltimore 5. Social Security Number Funeral 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) Director 217-70-1113 Months Days Hours 1 XM 2 51 Country) Jan.30,1958 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. MD Baltimore it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rtment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2457 Seamon Avenue 21225 USA 11. Mantal Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? 1 XNever Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other than ' 21215-0036 12 Maintenance Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Clarence Wonson Bertha Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Jones 33rd St.Apt.#209 Baltimore,MD 21218 Baltimore, Permit. Pages 1 and 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) King Mem. Park 12/8/09 Donation 5 Other Specify Woodlawn, MD 22. Name and Address of Facility Wesley CV avis, Jr. FH 21. Signature of Funeral Service Licenses 2007 Eastern Ave. Baltimore, MD21231 23a. Part I. Enter the visal se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Atherosclerotic cardiovascular disease Immediate Cause (Final disease Death kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed /sician/Medical XUNPENDED AMENDED 23a,27,perm,E g899 1/5/10 TT Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the attending Live birth Fetal death Ectopic pregnancy past 12 months? Day Year Pregnant at time of death Other (Specify, Yes 2 No 9 Unknown Unknown P Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ ۵ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No. 1 🗸 Yes 2 No Vital this certif 25. Was case referred to medical Be 26.Place of Death (Check only one) Hospital: 1 Other₄ Inpatient 2 1 V Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Director: d in by the f Pending Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year

ORIGINAL

ss of person who complete cause of death (Item 23a)

Registrar's Signa

Pamela E. Southall, MD Assistant Medical Examiner

November 30, 2009

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jucqueline Kenneay November 8 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Country) 5. Social Security Number Age (In vrs. last birthday) Hours **Funeral** 436-82-728 11-12-1948 Director Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10b. County 10a. State 1 Yes 2 No Director 10g. Citizen of What Country? 23a Funeral items . Was Decedent of Hispanic If Yes, specify Cuban, Mexi 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 ö Specify If Yes Give þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

310-Statistician 16b. Kind of Business/Industr er than "natur the Medical 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) tistician HARMACUE 7 is marked other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be မ Department of Health a Important: If Item 27 is any injury or other trainonce, Durial 2 Cremation 5 Other (Specify) 4 Donation Services 21. Signature of Funeral Service Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OVERTIEN **Physician** disease or condition resulting in death) iancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER or Atter ding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician are for use as the burialby Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I Unknown 9 KUnknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, 2 No 3 Probably 4 Unknown HYres 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an As piration has 25. Was se referred to medical 1 Yes 2 No 1 TYes certificate 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred

Subject choked on vitamin pill 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 11/08/2009 Unknown M 1 ☐ Yes 2 🗶 No Director Al 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11548 Jamestown Ct. Laurel, MD 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide Home To the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05/2009 Les-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

Registrar

State

31. Date filed (Month, Day, Year)

4 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09051 State of Maryland / Department of Health and Mental Hygiene 2009 38903 Joseph Kufera 1- For State Certificate of Death Req. No Registrar 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 21, 2009 0350 hrs Joseph A. Kufera **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Rel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Funeral Country) Months Hours Min Director 216-96-9037 1 XM 2 F 44 11/25/1964 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ij 1 Yes 2 XNo s 23a or 28a-f show notified at once. US Joppa MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number 1110 Plaza Circle 21085 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes White Specify: Yes 2 No specify: Divorced If Yes Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ant of Health and Mental Hygiene.

11: If item 27 is marked other than 'other traumatic event, the Medical 21215-0036 Laborer Labor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Linda Parker Joseph G. Kufera (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) timore. MD Baltimore, MD Joseph G. Kufera 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State Glen Burnie, MD 12/5/09 Atlantic Cremetory Donation 5 Other Specify eture of Funeral Se 22. Name and Address of Facility ce Licens Skarda Funeral Home 2829 Hudson Street MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last trar Physician/Medical UNPENDED AMENDED /sician a certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy phy: the t 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Month Day Fetal death Live birth use as Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown 9 Unknown icate has been signed by the page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown Š Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other; examiner? Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 uneral dire this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Motorcyclist struck a fixed object Certification: Nov 21, 2009 0111 hrs Natural 1 Yes 2 ✔ No Pending Director: hours after death. 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Could not be or Town, State) Philadelphia Rd & Raphel Rd, Kingsville, MD Suicide determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature November 21, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD 31, Date filed (Month, Day, Year 32. Registrar's Signature State Ball Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

	P.O. Box 68760
TADYSLAW KULIGOWSKI	Division of Vital Records,

			Pleas	e Type or Pri					-		Legible	
		•	For State Registrar		aryland	_	artment of F tificate of L			Reg. No.	2009	38904
	Physicia Medic		1. Decedent's Name (First, Middle, Low Wladyslaw Kuligo	wski					2. Date of Dea		200 gar	3. Time of Death 3:40 Рм
	Examir	er	4a. Facility Name (if not institution, gir Stella Maris Hos				4b. City, Town, or Location of Death Timonium			4c. (County of Deat Raltin	
	Funeral Director		5. Social Security Number 6. 212–46–7889		e (In yrs. Ia 86	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day (1/20/	1923	9. Bir PO	thplace (State or Foreign untry) ATIC
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A			Town or Loc						10d. Inside City Limits 11 Yes 2 □ No
	ith the M 3a or 28 t be not	ral Dir	10e. Street and Number	Charact	200	CLINOL	10f. Zip Code 21224			10g. Citiz	zen of What Co	ountry?
980	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	ed by Funeral	440 S. Folcroft 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E			Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🕅 No	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White	
Maryland 21215-0036	led within 72 hour Hygiene. other than "natu ent, the Medical	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)		i+)	(Give I	dent's Usual Occup kind of work done o O NOT use retired) inist		· ·		od of Business ernment	Industry Contractor
land 2	d be filed w Mental Hyg arked othe	o l	17. Father's Name (First, Middle, Last Stanislaw Kuligo	•					er's Name <i>(First, Middle, Maide</i> Lyslawa Deskie		•	
Man	12 should alth and Patth a		19a. Informant's Name/Relationship Stefania Kuligows				ng Address (Street a			-		and 21224
Baltimore,	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injuy or other traumatic eventonce.	13	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	CE	emetery, cren	sition (Name of natory or other place CY COMETE		Date 7/2009		cation - City or	Town, State Maryland
Balti	permit. P Departm Importa any inju	F 13	21. Signature of Funeral Service Lice		_12							/land 21231
	Pnysician/	0 06	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	one cause on each line).		er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. PROSTATI Due to (or as								
\$.	executed ian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or finjury that initiated events	Due to (or as								
	ite be exec hysician a he burial-1	ᇹ	resulting in death) Last	Due to (or as	a consequ	ence of):						
. Box 68760	or Attending Physician: The law requires that the death certificate be after death. Inter death. Director, After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3	Ectopic pregnanc Other (specify)	y		2	3d. Date of de Month	livery Day Y ear
ds, P.O.	requires that the dea been signed by the a should be detached f	ed by Pr	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause giv	ren in Part I.				the cause of death?
Records,	The law requi	Completed by							24a. Was a autop perfor	sy rmed?	prior to death?	topsy findings available completion of cause of
of Vital	sician: The certificate lirector, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 🗶 No	Hospital:		ER/Outpatien	Othe	er:		63	V	ify) HOSPICE
on of \	ttending Phys death. :tor: After this r the funeral di		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigati	28a. Date of inju (Month, Day	ry	28b. Time of injury	28c. Injury work	/ at	28d. Describe h			ny HOSFICE
Division	ial or Attenoss after death	I Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At hor c. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	nd place,	and due to the	cause(s) and manner stated.
	To t		29b. Signature and title of certifier	OCHNP			29c. License	number 19792	. :	29d. Date	signed (Month	n, Day, Year)
	b						LLEY RD.	TIMONIU	JM, MD 2	1093		
	Sta Registr		31. Date filed (Month, Day, Year) OEC 0 7 2009	32. Registra	ar's Signati							
DHI	MH 17 Rev 7/2	nna	-	Tark Till III	7.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GEORGE Year LOWE RANKLIN DECEMBER 3 2007 9:40 BM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 20, Birthplace (State or Foreign Country) 1 M 2 □ F Days Hours 214-26-4576 Months Min. 78 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1724 Webster Street 21230 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married Black, White, etc. 1□Yes 2♥No 3 ☑ Widowed 4 ☐ Divorced Year or Dates Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Electrician McCormick & Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unkown Lowe Rose Unkown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne D. Lowe (Son) 1303 Aster Drive, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Dec. 08, 2009 Brooklyn Park, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licens 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Cancer With Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to the iung Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Michael Event had not also sonce.

Baltimore, Maryland 21215-0036

Examiner

ģ signed

has been

this certificate

Hospital or Attending

IF FEMALE:

examiner

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifie

1 Yes 2 No

5 Pending investigation

6 Could not be determined

attending physician and for use as the burial-tran detached

Division of Vital Records, P.O. Box 68760

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A State

Registrar

Physician/Medical þ Completed Be 25. Was case referred to medical Certification: To 27. Manner of Death 29a. Certifier

28a. Date of Injury (Month, Day, Year)

29c. License number RES

MICCONTINUE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

DECEMBER 3 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

000

autopsy performed 2 **2** No

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN GEORGE, MD BOOI SOUTH HANOVER STREET, BALTIMORE, MO

31. Date filed (Month, Day, Year) BEC 0 7

usanx

32. Registrar's Signature



1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28b. Time of

21225

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38906 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** November 28, 2009 03:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON f Under 24 Hrs. 8. Date of Birth Min. (Month, Day GREATER MEDICAL CENTER BALTIMORE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours 213-96-8660 17 M 2□ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Director rmore 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 2121 Funerail Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed Forces? Black, White, etc 1 Yes 2 Kif Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aboner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delores မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE Demelna Similler 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of runeral Service License Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease condition resulting in death) PULMONARY EMBOLUS DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed h 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗆 Yes 2 🗌 No 3 ☐ Probably 4 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy 1X Yes 2 □ No r this certificaral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1X Inpatient After this funeral of . Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident after death.

Director: Af d in by the fur 1 Yes 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours aft

To the Funeral DI

completely filled in

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
· (red in)	D43003	11/30/2009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
NATHAN A. DUNSMORE, M.D., 6701 N CHARLES	ST., BALTIMORE, MAR	YLAND 21204
31. Date filed (Month, Day, Year) OFC 0 7 2009 32 Registrar's Signature	s.d	

State

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 4, Physician **TVAN** MARTSENYUK 2009 12:05 A. z. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner KELBOURNE ROAD APT. 201 ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days **X**□ M 2□ F UKRAINE Director 80 216-41-3818 Usual Residence of Decedent 5/6/1929 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Madical Everning. Trust be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2019 KELBOURNE RD. APT. 201 Funeral 21237 UKRAINE Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🏋 No À Specify Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER BUILDING 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ZAKHARIYA MARTSENYUK ဥ anna huk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) YEKATERINA MARTSENYUK/WIFE 2019 KELBOURNE RD. APT. 201 ROSEDALE, MD 21237 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM! 12/7/2009 PARKVILLE, MD 22. Name and Address of Facility 21. Signature of Euneral Service Licensee MOO2 17 THE JOHNSON FUNERAL HOME. P.A. 8521 LOCH RAVEN BLVD. TOWSON, 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yeons **Physician** rostoli /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauca. Exitat Undership Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed Exam sician and burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ္ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp leted cause of death (Item 23a) (Type, Print) Square Dr. Svite 2001 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 1, Day 2009 Physician 11:16 PM Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico Peninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours 89 March 19, 219-05-6370 Maryland Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Wicomico Pittsville Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" any injury or other traumant. 34907 Railroad Avenue 21850 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personel Director A.A County Health Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Horace Sheffer. Sr. Emma Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis M. Miller (Daughter) 34907 Railroad Avenue Pittsville, Maryland 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cemetery 4 □ Donation 5 □ Other (Specify) 12/04/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Abdomina /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I). Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 12 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 2, 2009 D58755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Arzadon 9714 Healthway Drive Bertin MD 21811 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anne McNelis <u>2</u>005 December 9:50 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death . County of Death Baltimore 210 Belmont Forest Court #102 Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 屎 F Months Days Hours Min. 216-82-3014 88 ADP 1 Day Year) Irerand Director 1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 210 Belmont Forest Ct., #102 21093 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specity Cuban, Mexican, Puerto Rican, etc.' Black, White, etc. 1 Never Married 2 XMarried Completed by 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", White 3 Widowed 4 Divorced Specify. Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental h 0'Carroll William Alexander Catherine Burbage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a Dr. Desmond P. McNelis-husband 210 Belmont Forest Ct., #102 Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State permit. Page 1 Department of Dulancy Valley 1 X Burial 2 Cremation 3 Removal from State 12/7/09 Timonium, MD 21093 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. <u>1050 York Rd., Towson, MD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate iterval Between Immediate Cause (Final Physician/ disease or condition resulting in death) 0 Medical Due to (or 🐧 a q sequence of: ^{*}Examiner Sequentially list conditions. any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit that initiated events o (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 🎗 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signatur and title of certifier 30. Nane and address of person who completed cause of death (Item 23a) (Type, Print) Suite 312, Towson, MD 21204 50 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

McNelis

Anne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38910 Certificate of Death 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Physician/ 2009 12 04 P M Herbert 0. McGuire Medical 00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3 0 Good Samaritan Hospital Baltimore City 5. Social Security Number 0 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F oct8,1938 Maryland Director 212-36-3727 9 Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No GUIRE Md. Baltimore City 10e. Street and Number 10g. Citizen of What Country? 23a 5615 Hilltop Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify. 3√ Widowed 4 □ Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12th Route Sales Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charles McGuire Charlotte Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, |5615 Hilltop Avenue Baltimore, Md. 21206 Kimberly McGuire/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4, 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA Kyhnt 1201 Dundalk Avenue Baltimore, RBER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** ACUTE RENAL FAILURE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury ISCHEMIC CARDIOMYOPATHY that initiated events resulting in death) Last Due to (or as a consequence of) ing physician a Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed? death? 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital ledical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier RES 000 December 02,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN KUMAR BLVD BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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		4a. Facility Name (if not institution, give street and number)	4	b. City, Tow	n, or Lo	cation of Dea			c. County of Deat	h	
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Baltimore, MC permit. Pages 1 and 2 s Department of Health as Important; If item 27 injury or other traums			e of Disposit natory or oth Z1O1				Date		c. Location - City o		
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Division of Vital Records, P.O. Box 6876. Hospital or Attending Physician: The law requires that the death certificate 44 hours after death. Funeral Directors. After this certificate has been signed by the attending physicial physicia	5				g				No 3 Pro		
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19		30. Name and address of person who completed cause of death (Item 23a	э)							1000	
Orber		Pamela E. Southall, MD Assistant Medical Examir	,	1 Penn S	treet,	Baltimore,	MD 21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death December 5, 2009 Pfeifer Helen 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days 1 □ M 2 □ **Y**F Months Yrs. 17, 1915 Maryland 10b. County 10c. City, Town or Location

1. Decedent's Name (First, Middle, Last) **Physician** 10:05 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner Oak Crest Care Center 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 212-05-1134 Director Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modest Examility must be not filled at 28a-f show 1 □Yes 2 No Directo Marvland <u>Baltimore</u> Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8800 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed by Specify: 3√ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Parker Mitchell 2 Walter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1993() 31637 N. Seaview Drive Bethany Beach, Delaware <u>Stephen T. Mitchell Son</u> 20b. Place of Disposition (Name of cemeter), crematory or other place)
Sacred Heart of Jesus Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5/2 Other (Specify) 12-19-2009 Baltimore Maryland 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Michael Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ebility /Medical Due to (or as a consequence of): Examiner Alzhermers Disease Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Due to (or as a consequence of) the attending physician thed for use as the burla Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes P No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an cate has page 2 s autopsy performe certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours. Her death.

To the Funeral Infector: Afier this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number R171944

State Registrar

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CRAY MIN 8800 Walther Blvd, Packville, MD 21234

LENP MSM

address of rson ho competed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Harrion

G.

		•	1 - State Amend Items 25,27 per me, g898,	artment of Health and N 12/04/09dhb ertificate of Death	Mental Hygio	ene g. No. 2009 38913			
Ph	ysicia	n/	1. Decedent's Name (First, Middle, Last) Thomas W. Queen Jr		2. Date of Death	Dov Vees			
	Medic xamin	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Novemo	e Y 8 2009 0444 M			
	Aannin	CI.	Anne Arundel Medical Center	Annapolis		Anne Arundel			
	neral ector		5. Social Security Number 219-13-7475	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Birthplace /State or Foreign			
			Usual Residence of Decedent		Polico v.T	I S T X TIGIT Y E SATE			
yland	ed at	ctor	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits			
e Mar	r 28a	Director	Maryland Anne Arundel Severn	a Park 10f. Zip Code	1 :	1 ☐ Yes 2 🛣 No			
with th	st be	eral	448 McBride Lane	21146	10	g. Citizen of What Country? USA			
leath	rems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	? (Specify Yes or No-				
land 21215-0036 be filed within 72 hours after death with the Maryland mital Hyglene.	rem z./ is marked other than "natural", or items z.aa or z.aa-f snow other traumatic event, the Medical Examiner must be notified at	d b	1 A Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No	1 Yes 2 No Specify:	nican, etc.,	Black, White, etc. Specify: Black			
5-0C	fical E	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Compute	- 11	6b. Kind of Business Industry			
21. 10 72 16.	State								
ed with	nt, th	BeC	12th 0 Use	r Support Specia		Board of Elections			
Maryland 21215-0036 2 should be filed within 72 hours after this and Mental Hygiene.	rked c	ē	Thomas W. Queen Sr	Viola !	e (First, Middle, Ma Pitts	aden Surname)			
Maryl should and Me	is ma aumat			ing Address (Street and Number or Rura	l Route Number, C	City or Town, State, Zip Code)			
and 2 s Health	her tr					Park, Md. 21146			
Baltimore, permit. Page 1 and Department of Hea	important: if ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (Specify) Memoria	al Park 11-	16-09	Oc. Location - City or Town, State Glen Burnie, Md.			
Balti permit. Departr	any inj			Mame Radesen Aim Son: 821 West St. Ani					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t, oximate terval Between			
Physi	cian, dical	ı	Immediate Cause (Final disease or condition resulting in death)	Hother Main 1	C41/V/0	Onset and Death			
	niner		Due to (or as a consequence of):		1				
7	#	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	IliM	CERTIFICATION APPROVED BY MEDICAL EXAMINER				
cecuter	Il-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last C	JUV CONTION API	PROVED BY MEDICA	T EXMI			
: 68760 certificate be executed inding physician and	the burial-transit	dical	d	CERTIFICATION					
687¢ sertificat	as th	Mec	IF FEMALE:						
Box 6 e death cer	should be detached for use as t	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year				
that the	detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?			
cords, law requires	onld be	ted k			1 ☐ Yes	3 Probably 4 Unknown			
Vital Records, social relations of the law requires is certificate has been significate between significant participations and the significant between the significant bearth between the significant between the significant between the	age 2 sh	Completed by			24a. Was an autopsy performe	ed? death?			
ian: T	ctor, p		25. Was case referred to medical examiner?	26. Place of Death (Check		M NO THE 2 HNO			
† VII	al dire	욘	examiner? 1	4		ce 6 Other (Specify)			
on o ending l eath.	he funer	Certificate:	Totural 5 ☐ Pending (Month, Day, Year) injury	of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred			
DIVISION OF tal or Attending Pars after death.	ed in by t		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
DIVISION Of VITAI RECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has	pleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time, date and	place, and due to the cause(s) and manner stated.			
To t	COUL		29b. Signature and title of bentifier	29c. License number	290	d. Date signed (Month, Day, Year)			
			30. Name and address of person who completed cause of death (Item 23a) (Type/	Print) Ax/y Ava	Annex	e/w, MD			
Re	State egistra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Stal					

09-09363	
Jeffrey M. Redit	er

09-09363		Please Type	or Print in Bl	lack Indel	lible lı	nk. Ensure	e All Copie	es Are Le	gible.		
leffrey M. Redife			of Maryland	/ Departm	ent of						9 3891
		Registrar		Certino	ale Oi	Dealli			leg. No.		
Physicia Medical Examii	ner	1. Decedent's Name (First, Middle, La Jeffrey Michael	Redifer					2. Date of Dea Month Decembe		Year D9	3. Time of Death 1501 hrs
1		4a. Facility Name (if not institution, gi Saint Josephs Hospital	ve street and number))		4b. City, Town, or Towson	Location of Death	ath 4c. County of Death Baltimore County			
Funeral		Social Security Number 6. 8	Sex 7. An	je (In yrs. last bii	rthday)	If Under 1 Year	r If Under 24Hrs	8 Date of Bi			
Director	- 1	220-96-6307	M 2 F 44	45	Yrs	Months Days		09/10/	1 964	1965 Foreig Cou	hplace (State or n untry)Maryland
) å	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Locat	ion					10d. Inside City Limits
* <u>* </u>					timor						1 X Yes 2 No
Maryland 28a-f show d at once.	호			рат	LIMOI						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Nential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ä	10e. Street and Number 6226 Northwood Dr	:.			10f. Zip Code 21212	2			en of What Cour ted Stat	
ath with	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 X Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1								0- 1	4. Race - Ameri White, etc.	can Indian, Black,
The second secon								s	Specify: whi	ite	
ours	호[15. Decedent's Education (Specify	only highest grade cor	mpleted) 16a.		nt's Usual Occupat			16b. Ki	nd of Business/I	ndustry
336 thin 72 thethan "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 2	5+)	•	ductor	. DO NOT use let	iieu)	ra	ilroad	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Nenhal Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica	9	17. Father's Name (First, Middle, Las					18.Mother's Name				
21, be fill mtal F	шĮ	Robert Bert Redi	fer				Judith	Helen	Jone	S	
ould d Me	유	19a. Informant's Name/Relationship				g Address (Stree					
MC d 2 st d 2 st ith an n 27 i		Alicia Redifer/wi	ife	1	6226	Northwoo	od Dr.	Baltim	ore,	MD 212	212
re, land		20a. Method of Disposition 1 X Burial 2 Cremation 3	Domayol from St			sition (Name of cer ther place)	metery,	Date	20c. L	ocation - City or	Town, State
MO Page Tent o		4 Donation 5 Other Specif					ens Dec	. 11,200) 9 E	Baltimor	e, Maryland
alti rmit. spartn spartn sports jury o	1	21. Signature of Funeral Service Lice			32	Name and Address	of Facility	Funora	1 Hor	mo Inc	
a a a a		Serus Mitche	ll		650	Name and Address tchell-W 00 York I	Rd. Ba	1timore	, MD	21212	
Physician		23a/Part I. Enter the disease, or comfailure. List only one cause on e		the death. Do r	not enter t	the mode of dying,	such as cardiac	or respiratory ar	rest, shoo	ck, or heart	Approximate Interval Between Onset and
/Medical kaminer		Immediate Cause (Final disease	Cardiac a	rrhythm	ia a	ssociate	d with c	ardiome	galy		Death
	- 1	or condition resulting in death)	Due to (or as a cons	sequence of): a	nd he	ealed my	ocarditi	S			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of:							
	xaminer	cause. Enter Underlying Cause	c.	sequence or,							
nsit		events resulting in death) Last	Due to (or as a cons	equence of):							
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and I director, page 2 should be detached for use as the burial - transi	sician/Medical E		X AMENDED #7&	3a,2/,p 8 per M	ermE E g8	, g899 1, 98 12/17	/13/10 T /09 TT	Т			
Box 68760 death certificate be the attending physical for use as the bu	Š	IF FEMALE:	23c. If yes, outco			30 12/17	707 11		23d	. Date of deliver	/
68 certifi	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	t time of death	_	etal death 3	Ectopic pregn	ancy		Month [Day Year
X = 1											
D. B. It the de by the ached f		Part II. Other significant conditions		th but not resulting	ng in the	underlying cause of	given in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
P.O.	2				•		~	1 Y	es 2	No 3 Proi	pably 4 V Unknown
cords, P.C law requires that has been signed b	jeo	1						24a. Was	s an	24b. Were au	topsy findings available
COF law r has b	흴								psy ormed?		completion of cause of
Vital Records, system: The law require this certificate has been sidirector, page 2 should be	Completed							1 Yes			es 2 No
tal clan: certif ector,	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check				
ig it is sid right	0	1 ✔ Yes 2 No	1 Inpatie	ent 2 🗸 ER/0	Outpatien	t 3 DOA	Other, Nursi	ng Home 5	Resider	nce 6 Othe	r:

Division of Vita To the Hospital or Attending Physicis within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral direct

3rd

OCME 2006

DHMH 17 Rev 1/2001

Ling Li, MD 31. Date filed (Month, Day Year) State Registrar

Medical Certification:

2

3

27. Manner of Death

Accident

29b. Signature and title of certifier

1 X Natural

29a. Certifier (Check only one) 2

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 82. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

Pending

6 Could not be determined

Investigation

30. Name and address of person who completed cause of death (Item 23a)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

28d. Describe how injury occurred

OCME

28f. Location (Street and Number or Rural Route Number, City

December 3, 2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38915 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth R. Ragland December 3, 2:34 P M 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edenwald Towson Baltimore If Under 1 Year Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 219-28-1324 1 🗆 M 2 🗓 F Months Days Hours 10-5-1919 Director Virginia 90 Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed with n 72 hours after death with the Maryland ment of Health and Mental Hygiens. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits MD Baltimore Towson 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8 Theo 21204 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) Elementary 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Teacher 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Creed Robinette Christina Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Theo Lane Towson, Maryland 21204 Clara Ann Ray / Niece 8 Theo Lane Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/7/2009 Hilltop Serv. Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TOWSON, Maryland 21204 Signature of Funeral Service Ruck TowsonFuneral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 funeral within 24 hours a

To the Funeral C

completed filled

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No		
25. Was case referred to medical examiner?	26. Place of Death (Check o	nly one)		
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 Other (Specify)		
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	on M 1 Yes 2 No	d. Describe how injury occurred		
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
(Check Medical Example (Check Property Medical Example (Check	ysician: To the best of my knowledge, death occured at the time, date and place, and on niner: On the basis of examination and/or investigation, in my opinion, death occurred at the reperson of the best of my knowledge, death occurred at the time, date and place,	e time, date and place, and due to the cause(s) and manner states		

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day

who completed cause of death (Item 23a) (Type, Print) buerne

Registrar's Signature

Brandon Jevome Sounders Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-09215 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2009 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Saunders Month November 27, 2009 0740 hrs Medical Examiner Jerome 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Edgewood 658 Yorkshire (Rear) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Country) Days Months Hours 04-08-1985 Director 216-08-1210 1 V M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State iny Yes 2 UNO Daltmore narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 20 indSa11 Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Yes 2 No specify: Specify Divorced Yes, Give Year Widowed tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Libert College (1-4 or 5+) Elementary/Secondary (0-12) imore, MD 21215-0036
Pages 1 and 2 should be filed within 7:
nent of Health and Mental Hygiene. 12-16 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Saunders Carter michael 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Straw Flower RA, AptC. Essex. mD: 2122/ mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Itimore, crematory or other place) Cremation 3 Removal from State 1 Burial 2 8-09 5 Other Specifi 22. Name and Address of Facility 21. Signature of Funeral Ser F.H Bacto, md. Approximate Interva or the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure List only one cause on each line. /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate squea. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical attending physician a for use as the burial -AMENDED UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ð Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other: examiner? Hospital: Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Certification: Subject shot FOUND: Division Natural Yes 2 V No Pending the Nov 27, 2009 0730 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. completely filled in by Could not be or Town, State) 658 Yorkshire (Rear), Edgewood, MD Suicide determined (Specify) Yard 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 28, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. 32. Registrar's Signature State known

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Harold 2009 <u>11:0</u>5 P [™] Shreves December 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8001 Pine Barren Court Pasadena If Under 1 Year | If Under 24 Hrs. | Anne Arundel

9. Birthplace (State 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F te or Foreign **Funeral** Country) Months Days Hours Min Yrs. Director 214-22-1723 83 13. 1926 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Expraner resist be notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 8001 Pine Barren Court 23a 21122 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 □ Yes 2 □ No Specity: 2 Specify: 3 Widowed 4 Divorced "natural". White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) filed withir I Hygiene. College (1-4or 5+) 6 N/A <u>Maintenance</u> Coffee Company other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stark ည Shreves Polly Watsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Charlotte M. Shreves (Wife) 8001 Pine Barren Court Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Pk. 12/05/09 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme ate Cause (Final disease or condition resulting in death) Onset and Death **Physician** V Par menta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enta Underlying Cause (Disease or injury that initiated events resulting in death) Last ne Due to (or as a consequence of): that the death certificate be executed Exami and Due to (or as a consequence of): physician s the burial Physician/Medical as attending for use as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specity) ed by the Ö 9 Unknown 9 Unknown signed by to be a detach ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate of Vital 1 ∐Yes 2 🛂 No 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \sum Nursing Home 1 Yes 2 ₺ N Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Desidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending death. investigation 1 □Yes 2 □No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 5 0 29c. License number 29d. Date signed (Month, Day, Year) 02 Type, Print) 30. Name and address of persor who completed cause of death (Item 23-1) Elliott 40 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 38918 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 Рм Ronald Smith December 3:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1988 Poplar Ridge Road Anne Arundel Pasadena 8. Date of Birth (Month, Day, Ye Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Maryland Director 212-30-5624 1933 76 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗆 Yes 2 🔀 No Marvland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1988 Poplar Ridge Road 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Claims Authorizer Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Smith Weibking Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Smith (Wife) 1988 Poplar Ridge Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Cremation 12/04/09 Glen Burnie, Maryland 21. Signature of Faneral Service Licensee 22. Name end Address of Facility
McCully-Polyniak F
3204 Mountain Road Funeral Home, P.A. ad Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atter should be detached for in the past 12 months? Dav Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 5 Pending injury 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2106 man

State

32. Registrar's Signature

State

DHMH 17 Rev 1/2001 OCME 2006

Registra

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

and manner stated

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

no

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

29d. Date signed (Month, Day, Year)

December 2, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene 2 0 0 0

		_	For Amend Item	s 23arti, 27,	28a 1° Cer	per me, e tificate of L	1898 , 1270 Death	4709dHB	Reg. No.	09	38920			
F	Physicia Medic		 Decedent's Name (First, Middle, Last) Barbara Ann Smith 					2. Date of De Month	Day 16	Year 2004	3. Time of Death			
1	Examin		4a. Facility Name (if not institution, give street Union Mem. Hospit	and number) al		4b. City, Town, or Baltimo	Location of Death		4c. County	of Death				
	uneral irector		5 Social Security Number 6. Sex 1 □ M	2 🔯 F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug. 1	1952	9. Birthpla Country MD	ace (State or Foreign I)			
faryland	8a-f show tified at	rector	Usual Residence of Decedent 10a. State 10b. County MD		Town or Loc					100	d. Inside City Limits			
with the N	23a or 2 ust be no	Funeral Director	10e Street and Number 4808 Lorlley Ct.			10f. Zip Code 21206			10g. Citizen of What Country?					
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at	hygene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	þ	1 Never Married 2 Married	Vas Decedent Ever in U.S. vmed Forces? Yes 2 XNo Yes, Give ear or Dates.		/as Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)	Black	e - American k, White, etc Blac	C.			
Maryland 21215-0036 2 should be filed within 72 hours after tith and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		Completed	15. Decedent's Educati (Specify only highest grade co	mpleted) sollege (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d NOT use retired) . ng	ation uring most of work	ing	16b. Kind of Bu		stry			
land is	nd Mental Hyg marked othe imatic event,	To Be	17. Father's Name (First, Middle, Last) James McBride				18. Mother's Nam		Maiden Surname,	_				
, Mary	int of Health and Menta t: If item 27 is marked y or other traumatic e		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State 705 S. Avondale Ave. Baltimore, MI								de) 1222			
Baltimore,	пелt of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State ce	metery, crem	ition (Name of atory or other place remator	e)	Date 27/09	20c. Location - Hanove:	•	n, State			
Balt permit.	Department Important: I any injury or once.		21. Signature of Funeral Service Licensee	of the		Name and Addres 07 East								
	sician/ Medical	. 3	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. East only one cause on part fine. Immediate Cause (Final disease or condition resulting in death) a. Du to (or as a consequence of):											
	aminer	i.		Hend to	au ma					<u> </u>	ix days			
ecuted	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c	Due to (or as a conseque			- 15	D BY MEDICAL EX	AMINER					
760 icate be ex	hysician the burial	Medical E	d			CERTIFICATION APPROVED BY MEDICAL EX								
. Box 687 e death certifica	when the fundation teacher. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	in the past 12 months?	yes, outcome of pregnan Live Birth 2 Fetal Pregnant at time of de	death 3 🗌	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date Mor	e of delivery				
dS, P.O. quires that the	en signed by ruld be detad	۵	Part II. Other significant conditions contribu	iting to death but not resul	lting in the ur	derlying cause given in Part I. 23e. Did t			obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
Records,	cate has be ; page 2 sho	Completed							rmed? p	Vere autopsy prior to comp leath? Yes 2	y findings available pletion of cause of M No			
Vital ysician:	is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	tal:	R/Outpatient	Otho	r: 4 Nursing Ho		lence 6 🗆 Other	r (Specify)				
UVISION OF tal or Attending Ph	or After th		1 Natural 5 Pending . 2 X Accident Investigation	8a. Date of injury (Month, Pay, Year)	28b. Time of injury	28c. Injury work?	at	28d. Describe h	ow injury occurre	ed				
DIVISI	al Direct		3 ☐ Suicide 6 ☐ Could not be determined	Be. Place of Injury - At hom building, etc. (Specify) Street	ne, farm, stre	et, factory, office		28f. Location (S City or Tow Moravia	(Street and Number or Rural Route Number, wn, State) 5800 Block of a Road, Baltimore, MD					
he Hospit	the Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Confusion 3 Certifying Nurse Pra	n the basis of examination :	and/or investi	gation, in my opinior	n, death occurred a	t the time, date a	nd place, and due	to the cause	e(s) and manner stated.			
Tot	To t		29b. Signature and title of confifer	w		29c. License	number 24389	46	29d. Date signed	(Month, Day				
			30. Name and address of person who complete the second sec	ted cause of death (Item 2		int)	MD	31718						
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	for and	las								

			- State Amend Items Registrar	State of Maryla 5 25,27,28a-1 p	and / Departmer per me, g898, <i>Certifica</i> i	nt of Health and 12/04/09dhb te of Death	Mental Hygier Reg. 1		38921
	Physicia	an	1. Decedent's Name (First, Middle,	Last)			2. Date of Death Month	Day Year	3. Time of Death
17	/Medic	al	Frances 5	teaciman -	- lurne		November		9:25 AM
	Funeral Director	er	DI 10 LOTA	icher Hos	pice	Town, or Location of Deat Control of Deat Graph Control Graph C	8. Date of Birth	4c. County of Death A A 9. Birthpla County	ace (State or Foreign
	TO		Usual Residence of Decedent		17		July 31,	1915 NOM	th Carotina
	he Marylan 28a-f show	Director	10a. State 10b. County	A 100. 0	Bouth r	nore			d. Inside City Limits 1 ☐ Ves 2 ☐ No
	aa or 3		10e. Street and Number	risan Pl	Vd . 101. 21	21215	10g.	Citizen of What Countr	y?
ME	es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I fleen 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, If we didn't examine the mailined at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Never Married 2 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13. Was Dece If Yes, spe 1 □ Yes	edent of Hispanic Origin? (S acity Cuban, Mexican, Puerl 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, et	
13 5	72 hou	eted	15. Decedent's (Specify only highest	Education	16a. Decedent's Usu	ual Occupation	rkina 1	Kind of Business/Indu	ıstry
2121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sing	ork done during most of wor ise retired)	E	nterta	nnert
Maryland	should be find Mental Hamarked ot	To Be	17. Father's Name (First, Middle, L Emmanuel	Rankin		18. Mother's Nar	me (First, Middle, Maid	en Surname) Od me ad	,
lary	2 shou and M is mar	-	19a Informant's Name/Relationshi	p (Type. Print)	19b. Mailing Address	s (Street and Number or Ri	ural Route Number, Cit	y or Town, State, Zip (Code)
	1 and 2 Health em 27 Ither tr		Kaymond 20a. Method of Disposition	lurrer- Sor) 2702 (sarrism	Blvd,	Baltimore	/
altimore,	Pagnent nnt: I		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	B ☐ Removal from State ecify)	cemetery, crematory or o	Cemety 121	3/2009 L	Baltma	is, state
Ba	permit. Departn Importa any Inju		21. Signature of Far ral Service L	cens e	1. 4600	nd Address (Facility	leights t	TWIPALT	. Home
			23a. Part 1. Enter the disease, or o shock, or heart failure. List o	omplications that caused the de			c or respiratory arrest,	ioc, Dari	Approximate Interval Between Onset and Death
Ó	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	- 54hd//	JAMA	TOMO	1		040115
	LAdillilei	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):		11 Acry	Then	W
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		CERTIFICATION APPROVE	D BY MEDICAL EXAMINE		
£ 09	ificate be executed g physician and is the burial-transit	cal Ex	resulting in death) Last	Due to (or as a conse	equence of):	CERTIFICATION			
25/		Medical	IF FEMALE:	u					
9 9. 0. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 Ectopic			23d. Date of deliver Month	y Day Year
/26/l	es the cigne	ρ	Part II. Other significant condition	s contributing to death but not re	esulting in the underlying o	cause given in Part I.		eo use contribute to the	
/// I Reco		Completed					24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
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When	g Physer this	n: To	1 Yes 27. Manner of Death	28a. Date of Injury	☐ ER/Outpatient 3 ☐ DO 28b. Time of	OA Uniury at Work?	fome 5 ☐ Residence		TOTALL
Sion	Attending r death. ector: After by the fune	catio	2 Accident 5 Pending investiga	127 207 2007	Found p Unknown	Work? 1 ☐ Yes 2 🛣 No	Subje	ct fell.	
Division	after date of Direct	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At building, etc. (Spe Home	home, farm, street, factor	y, office	28f. Location (Street City or Town, St	and Number or Rural ate)2/02 Gari d, Baltimo	Route Number, rison
rau		Medical C	29a. Certifier 1 vertifying (Check only one) 2 Medical E	Physician: To the best of my k xaminer: On the basis of exami and manner stated.	nowledge, death occurred ination and/or investigation	d at the time, date and plac n, in my opinion, death occi	e, and due to the caus	e(s) and manner as sta	ated.
14	To the within 2 To the comple	Me	29b. Signature and title of certifier.	1 . 16	29	c. License number	29d.	Date signed (Month, D	ay, Year)
			MUW H	MARCH MI		013012		1/26/0	14
(3)			30. Name and address of person w	ho completed cause of death (It	em 23a) (Type, Print)	due st	Bills	Mit 2	12/5
(d)	Stat		31. Date filed (Month, Day, Year)	32/Registrar's Sig	nature	100-11	701101	1114 0	70
_	Registra	.11	DEC A Z.	Comment of the commen	N M				

State of Maryland / Department of Health and Mental Hygiene 2 38922 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER. SUGAR 2009 ANNA 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗴 F Months Days Hours Min 63718/1920 217-05-2254 89 Yrs Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🕅 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral or items 23a USA 21209 7202 ROCKLAND HILLS DRIVE, #410 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event ၉ BESSIE MANEKIN SWARTZ **HARRY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 2407 SUGARCONE ROAD, BALTIMORE, MD PHYLLIS CUTLER / NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 12/4/2009 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OSSMUCTUR MONTH C disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 X/No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Division of Vital Records. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death Director: / Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by To the Hospital of within 24 hours a To the Funeral Completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature \sim 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 32. Registrar's signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 38923 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 5, 2009 2009 **EUGENIE TRUELOVE** 12:37A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Funeral Social Security Number 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. Sept 18, 1917 England Director 213-34-2996 92 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 ☐ No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2211 West Rogers Avenue 21209 England Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates White 3 Widowed 4 XIX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Lovett Elizabeth Emily Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard John Truelove 13 Elmwood Avenue Baltimore, Maryland 21210 Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 D Burial 2 XX remation 3 D Removal from State cemetery, crematory or other place) GreenMount Crematory | Dec 7,2009 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Malit Chell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ agestive Neart disease or condition Medical resulting in death) Due for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been shown show the owners. burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check .Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) K145356 tudo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) itala. Tousentown Tausan 31. Date filed (Month) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygieney 38924 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Rosie Lee Tilmon 11 26 2009 4:25 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 03/27/1917 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 92 Director 253-32-8907 Georgia Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 1520 W. North Avenue Apt.502 21217 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural; or ite Iny or other traumatic event, the Madical Exercis 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Grade Balto. City- Custodian Waxter Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis ဂ Wilcox Annie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2543 Francis St., Baltimore, MD 21217 Aretha Brooks (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Ponation 5 ☐ Other (Specify) Arbutus Cemetery 12/03/09 Baltimore,MD Ignature of Funeral Service Licensee ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., BAltimore, MD 21217 Dane 23a/Part1. Other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic huver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit s a consequence of): Box 68760. Physician/Medical 58 ettending p IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. ed by the e 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ cate hes been signated to page 2 should to Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2♥ No autopsy performed? certificate 1 ☐ Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA Atter thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No within 24 hours atter death To the Funarel Directors, completely filled in by the t 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZU Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55425 Munit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B MVEURA, JUD commanweath AV, catous le mi) 413 31. Date filed (Month, Day, Year) DEC 07 2009 32. Registrar's Signature barke State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38925 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 8:30 AM Thomas December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6th Street Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) (Nov. 24, 1953 1 □ M 2 🛈 F Months Days Hours Min **Director** Maryland 214-48-1651 56 Nov. Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Xyes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a Funeral U.S.A. 21225 6th Street 4803 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify. 3 XWidowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) First Elementary/Seconday (0-12) College (1-4 or 5+) N/A Annapolis Consulting Accounting Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gerhardt Henry L. Wauters Lorraine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall A. Thomas (Son) 225 New York Avenue Pasadena, Maryland 21122 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/7/09 Glen Burnie, Maryland Cremation . Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine 1051 0/10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury signed by the attending physician and dedected for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 ☐ Accident 3 ☐ Suicide 2 No Investigation 124 hours after deat e Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) ire and title of certifie 29b. Signat 29c. License number 29d. Date signed (Month. Dav. Year) 8 ause of death (Item 23a) (Type, Print) Mac

State Registrar 601

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31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 22 per FH G898 12/7/09 TT

State of Maryland / Department of Health and Mental Hygiene 38926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:18 AM DECGMBER Clyde Wiley James 200 Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 1 A M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. . Carolina 04/04/1951 **Director** 214-56-2609 58 Yrs N. Usual Residence of Decedent show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at. 10a. State within 72 hours after death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 2731 Winchester Street 21216 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th</u> Grade Cook BWI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Haywood Wiley **Emma** Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Wiley(Son) 1172 New Field Road, Baltimore, MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
3. Toseph Brown F/H
and Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/07/09 Baltimore, MD Joseph H. Brwon, Jr. F.H. ure of Funeral Service licens Fulton N. Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ INTRACRANIAL HEMORRHAGE disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner HYPERTENSION YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ner Due to (or as a consequence of) Exami Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 2 No g Unknown **Director:** After this certificate has been signed by in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2X No Hospital Other: ၉ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural (Month, Day, Year) 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined n 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated asmoyalam 29b. Signature and title of certifier AT2438946 MD 12/01/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day,

Year)

SASIMANGALAM, UNION MEMORIAL HOSPITAL, BALTIMORE, MD

32. Ragistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38927 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Warren Windsor December 2009 10:59 PM Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Good Samaritan Hospital Baltimore 5. Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 89 Months Days Hours Director 214-12-1306 920 Mary Land Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/ABaltimore Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21209 6104 Green Meadow Parkway United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. à 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: 3 X Widowed 4 ☐ Divorced white Completed Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) accountant hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wiltshire Walton Windsor Myrtle Lillian Kranz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Windsor/daughter P. O. Box 2418 Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State any injury or Dec. 4,2009 Green Mount Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ohn O. Mitchell J22, Name and Address of Farill TV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P.A. 200 E. Padonia Rd. Timonium, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dua to (or de a consequence of) 24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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Year) 2009

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Registrar's Signature

29d. Date signed (Month, Day, Year) 09

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	Physici	an	1. Decedent's Nam									2. Date of Death 3.			3. Time of Dea			
	/Medio		Gerald A. 4a. Facility Name (If not institution, give street and number				Wienke 4b. City, Town, or Location of Deatl					of Death,	Ultember 1, 2009 4c. County of Death				W - P	
	.		Mary la 5. Social Security N	, w	eneral	HOSP	pita	L hirthday)	Ball If Unde	4 4	He IIInde	C77	Data of Bir	th	1	V/A	on (State of Fo	ian
	Funeral Director		141–10–098	88	6. Sex 1 M 2 □ F	7. Age (II	-	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da April 2	in 1, Yea <i>r)</i> 1, 192	h y, Year) 9. Bii C		ace (State or Fo ry) Jersey	reign
	and w		Usual Residence of	f Decedent		10	c City 7	Town or Lo	cation	-						10	d. Inside City Li	mits
	n the Maryland r 28a-f show modified at	ţo	Maryland		Pasad					1 ☐ Yes 2 X								
	er death with tems 23a o	Jirec	10e. Street and Number				10f. Zip Code							10g. Citi	y?			
		erall	402 Sylview Drive 11 Marital Status 12. Was Decede			adant Eva	nt Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp						aif . Va a ar Na		U.S.A		n Indian	
e 036		Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Dece Armed For 1 □ Yes If Yes, Giv			orces? 2 X No ive	es? If Yes, specify Cub Mi No 1 □Yes 2 No				Specify	an, Puerto	Rican, etc.))-	14. Race - American Indian, Black, White, etc. Specify: White			
5.0		leted	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupatio (Give kind of work done durn life. DO NOT use retired)				ation during mo	st of workir	ng	16b. Ki	6b. Kind of Business/Industry			
Genell Wenke Baltimore, Maryland 21215-0036	within jiene. r than	ошр	Elementary/Second 12	1-4or 5+)	Plant Superintendent						Und	Uniroyal						
	tal Hyg d other	Be	17. Father's Name				18. Mother's Nam				(First, Middle	Surname)						
	d Men marked matic	은	Joseph 19a. Informant's Name/Relationship (Type. Print)			.	Wie					abeth					uskie	
recald	nd 2 salth an 27 is 1		Thomas Wie						•				al Route Number, City or Town, State, Zip adena, Maryland 21122			e, 21p (Joue)	
ore,	jes 1 a t of He If item or othe	3.6	20a. Method of Dis	sposition	3 ☐ Removal from	State	20b. Plac	e of Dispos etery, cren	sition (Na	ne of other plac	e)	D	ate	20c. Lo	cation - City	or Tow	n, State	
Ē,	urtmen urtmen urtant: njury	14		5 ☐ Other (S)	pecify)	(Cedar	Hill (12/07/0				rk, l	Maryland	
Ba	Depa Impo any I	Į. įį	21. Signature of Fi	United Service	icensee			M 3:	cCully 204 Mc	Poly untai	niak n Roa	Funera d Pasa	l Home, l dena, Mar	P.A. rvlano	1 21122			
			23a. Part 1. Enter t shock, or hea	the disease, or art failure. List	complications that conly one cause on	caused the	death.									1	Approximate Interval Between	n
	Physician /Medical	- 4	Immediate Cause disease or condition resulting in death)	on	-a. My	last.	hen		TRA	V/S							Onset and Deat	n
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np.	execute and al-trans	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	c	Due to (or as a consequence of):										-			
68760,	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical E		8	d													
_		/Med	IF FEMALE:		23c. If yes, ou	tooms of n										-		
P.O. Box		Physician/M	23b. Was deceden in the past 12 1 Yes 2 5 Unknown	nonths? □No		etal death 3 Ectopic pregnancy						23d. Date of delivery Month Day Ye ar						
		Ď	Cara Antaria Danas									obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown						
Division of Vital Records,		Completed									psy prmed?	sy prior to completion of cause of death?						
Vita	siclan certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outnatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific)															
) of	ig Phy ter this neral d	n: To	1 Iz Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Reside									ow injury occurred						
sior	tendin eath. tor: Af	catio	1 ☑Natural 2 ☐ Accident 3 ☐ Suicide		M 1 □Yes 2 □No													
Divi	al or At after d Direct d in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street at City or Town, State)									Street an wn, State	and Number or Rural Route Number, ate)					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Adth. certificate has completely filled in by the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director.	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
	To t With To t	Σ	29b. Signature and	title of certifier	PAYAL	- Pたて	EL /	UD	290		e number 02	9			e signed (Mo	onth, D	ay, Year)	
	10		30. Name and add	ress of person	who completed cause				Print)	Rull	and	G	enera	1 1	Jospi	tal	0	
	Sta Registr		31. Date filed Mor	onth, Day, Year)	UY (32. F	Registrar's	Signatur	pare	lad'									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38929 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sybil Diana Nutter Wimberley 2009 December 8:24 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13001 Dulaney Valley Road Glen Arm Baltimore Social Security Number 494-16-5862 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mi<u>ssouri</u> 1 □ M 2X□ F Months Days Hours Min March 8 Director 87 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Glen Arm 1 🗌 Yes 2 🖵 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Completed by Funeral 72 hours after death with 13001 Dulaney Valley Road 21057 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: White "natural" Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank C. Nutter Svbil Silkwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s F Health a item 27 i 13001 Dulaney Valley Road Glen Arm, Maryland 21057 James Wimberley / Son 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. Arlington Nat'l Cem 12/16/2009 Arlington, Virginia 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ BREAST CONOR META STATIL disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ω. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy this certificate 1 ☐ Yes 2 ☐ No 2 🗷 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **N** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after deaun.

To the Funeral Director: Aft work 1 Yes 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🕵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 38930 Reg. No 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Williams 03:12 AM (Jerome november 27 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA SINAI BALTIMORE HOSPITHLOF BACTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 0.3675 1 MM 2□ F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MD Baltimore 1 □Yes 2 No Randallstown Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? arriage Hill Circle Apt. 202 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. A Q Specify. Baltimore, Maryland 21215-003 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation enters of Medicare (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within College (1-4or 5+) Elementary/Secondary (0-12) computer 7alvst & Medicaid Services ty 12th grade vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Williams GENEVIEVE Fuguer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Indreal Williams Son 147 Bowman Street Mansfield OH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05 109 Mansfield 21. Signature of Funeral Service Licensee Vaughor Greene Funory services 22. Name and Address of Facility Vaus Road Randallstown MD 2113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUBBURAL **Physician** TRANATOM A disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) CERTIFICATI physician certificate be Physiclan/Medical the attending properties IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes No 24a. Was an page 2 s certificate Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: Natural 2 X Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 🙀 No Unknown M Unknown Subject fell. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Bural Boute Number. City or Town, State) 3510 Carriage Hill Circle, Apt. 202, Randallstown, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Home

P.O. Box Division or Vital Records, 5

> State Registrar

Medical

and manner stated. 29b. Signature and title of certifie

29c. License number

N46061

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed, (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

ROCIN

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2401

32. Registrar's Signature

29a. Certifier

MELANIA

Year)

4

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23aPt1, 11,25 per me, 2898, 12/04/09dhb Reg. No. 38**93**1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ o ctober James Donald Winter 9:50 AM 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Date of bill. (Month, Day, Year) Funeral Months Days Hours Min ^{Country)} West Virginia Director 86 1923 234-34-2377 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d Inside City Limits Director 1 Ses 2 No MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30th. Street Apt. 2E 300 E. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ★ Yes 2 □ No Completed by Black White etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates WWI 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Floyd Winter Maud May Tallman Page 1 and 2 should and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Jerry F. Neil /Friend 8205 Thornton Road Towson, MD 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o ō cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 0 4 ☐ Donation 5 ☐ Other (Specify) 2009 Beltsville, Maryland Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Alternatives MO 1442 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ BRADYCARDIA - SEVERE disease or condition resulting in death) ninote Medical Examiner coronary syndrome Sucuration if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury PROVED BY MEDICAL EXAMINER signed by the attending physician and dbe detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: Tie law lequires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Insufficiency 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has I autopsy performe 1 Tes 2 No 2 1 No 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending Accident
Suicide
Homicide Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P 29c. <u>Lice</u>nse number A 12438946 29d. Date signed (Month, Day, Year) mpleted cause of death (Item: 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

4

Union Memonial Hospital, 2018. University Protocol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 38932

		1- For State Certificate of Death Reg. No.																
Physici		1. Decedent's Name (First, Mi	ddle,Last)								2. Date of Death Month Day Year							
edical Exam	iner	Fannie		Williams						Month Day Year November 27, 2009 1509 hr								
		4a. Facility Name (if not institu	tion, give street and	number)	_	4b. Cit	ty, Town, or Lo	ocation of	Death		4c. County of	c. County of Death						
		Sinai Hospital		Ва	ltimore					Na								
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday	/) If L	Jnder 1 Year	If Under	24Hrs.	8. Date of Bir	rth (MM/DD/YYYY	9. Birthplace (S	tate or Foreign					
Director		219-22-8608	1 M 2 X I	93			onths Days	Hours	Min.	06-10	-16	Country) SC						
			I M ZAI	75		Yrs.				00 10								
È		Usual Residence of Decedent 10a. State 10b. Cour	tv	10c City	Town or L	ocation						10d Insi	de City Limits					
W al			•										es 2 No					
Maryland 28a-f show any d at once,	ō	MD	NA	l Ba	ltime								es Z No					
Mary 28a- d at	l S	MD NA BAITIMOTE 10e. Street and Number 2807 Roslyn Avenue 21216									0g. Citizen of What Country?							
vith the Maryland s 23a or 28a-f show s notified at once,	盲	2807 Rosl		21216				USA	USA									
with ms 23	Funeral	11. Marital Status	12. Was [Decedent Ever in U	.S. 13		edent of Hispa					- American Indian	n, Black,					
Jeath r iter	Ĭ	1 Never Married 2	Married Armed	Forces?		If Yes, sp	ecify Cuban, I	Mexican, F	Puerto Ri	can, etc.)	White	White, etc. African						
fter c	II.	3 X Widowed 4	Divorced If Yes, Give		1	Yes	2 X No	specify:			specify: American							
urs a fura amin	d by	15. Decedent's Education (S	pecify only highest of	rade completed)	16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industrial													
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5-0036 fled within 72 Hygiene. I other than	횰	6th Grade	NA		Home	e-ma	ker				other	her homes						
d wif	<u>Ş</u>	17. Father's Name (First, Mid	lle, Last)				18	3.Mother's	Name (F	irst, Middle,	Maiden Surname	Surname)						
215 be file ntal Hy rked o	Be	Robert	Bland	inc				Emma		Parker								
212 ould bould by I Ment	0				⊖ 9b. M	ailing Addı						, City or Town, State, Zip Code)						
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is market other than "natural", or items 23a or 28a-f sho injury or other trauntatic event, the Medical Examiner must be notified at once.	F	Arlene C.		a a g	1 280	07 R	oslvn	Ave	nue	Balt	imore,	MD 212						
and 2 ealth em 2		20a. Method of Disposition	ner ber t	20h			(Name of ceme			Date		City or Town, Sta						
Baltimore, permit. Pages I are Department of Hee Important: If ite injury or other tr.			ion 3 Remova	crematory of	or other pla	ace)					•							
Page Page nent ant:		4 Donation 5 Other	Specify:	B.			Nat'				09 Baltimore, MD							
alti mit partn port		21. Signature of Funeral Serv	22. Nam e	e and Address of Facility Wylie Funeral Home P.A.														
m gg E E	7 18	Shundle	, Jane	2		638	N. Gi	1mor	St	reet	Baltime	ore,MD	21217					
Physician		23a. Part I. Enter the disease		it caused the death	. Do not en	ter the mo	ode of dying, s	uch as car	diac or r	espiratory ar	rest, shock, or he		imate Interval					
/Medical	8 0	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardiovascular disease Between Onset and Death Death																
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive cardiovascular disease or condition resulting in death) Due to (or as a consequence of):																
	Je.	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):																
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F	Examiner	events resulting in death) Last Due to (or as a consequence of):																
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit			d															
D, be es siciar urial	n/Medical	X UNPENDED	AMENDE	per M	ME g899 1/22/10 TT													
68760, certificate be ading physici	ž	IF FEMALE: 23b. Was decedent pregnant i	23c. If ye	nancy					23d. Date of delivery									
68 certif ding	ian	past 12 months?	T LIN	1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify)								Day	Year					
Box e death c the atten ed for us	sic	1 Yes 2 V No 9	lakaowa '	Other (Specify)													
the d	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										ibute to the cause	of death?					
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v required should	jet	24a. Was an autopsy										24b. Were autopsy findings available prior to completion of cause of						
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iffica		25. Was case referred to med	ioni				26.Place o	of Dooth /C	Thonk on	Lo. 1000	2 No 1	✓ Yes	2 No					
ician ician s cerr recto	Be	examiner?	Hospital:	Inpatient 2 🗸	ED/0	# 4 2		Whor:] D:d 0 [Oth						
Division of Vital Records, rs alor Attending Physician: The law require and in the control of th	ို	1 ✓ Yes 2 No 27. Manner of Death		-		of Injury	28c. Injury			Home 5	Residence 6	Other:						
ding Aftr	Certification;	1 V Natural		ate of Injury onth, Day,Year)	200. 11118	e Or injury		_		od, Describe	how injury occurr	eu						
ivision or Attene after death Director;	ati		ending vestigation			1000	_	es 2 N	-									
IVISI or Att after de Direct	ij		tory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)						Number, City									
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To the Hospital within 24 hours To the Funeral completely filled	al (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.									e, date and place, and due to the cause(s)							
F S F S		29b. Signature and title of cer		29c. License	Year)													
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	Ň	O 11 AD					O.C.M	1.E.			December	1, 2009						
	M	Quate	on who completed a	ause of death /tten	1 23a)		O.C.M	1.E.			December	1, 2009						
	M	30. Name and address of pers		,	,	n Stree			21201		December	1, 2009						
	tate	30. Name and address of pers Ana Rubio MD. A	ssistant Medica	,	111 Per		O.C.M et, Baltimor		21201		December	1, 2009						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 38933 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BERNARD DECEMBER 3 2009 WEINSTEIN 12:46 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 8. Date of Birth (Month, Day, Year) 12/13/1938 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F 70 MD 218-32-8013 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🏋 No BALTIMORE MD PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SLADE AVENUE, 21208 #818 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify. 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) OPTOMETRIST OPTOMETRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAHAM WEINSTEIN NETTIE PINKOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARC WEINSTEIN / SON 11011 NACIREMA LANE, LUTHERVILLE, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BETH TFILOH CONG. 12/4/2009 | WOODLAWN, MD 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma disease or condition resulting in death) Due to (or as a consequence of) Mynestersion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Mynnlipidemia that initiated events resulting in death) Last Due to (or as a consequence of) Accuident exp bouvors cular IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ruse whan 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed ding physician Records, After this certificate Division or Vital or Attending Physician: after death within 24 hours a To the Funeral L

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events.

Physician

/Medical

Examiner

/Medical

Director

Funeral

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Physician/Medical

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Certification: To

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State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifler

HIROGERA 7505 31. Date filed (Month, Day, Year 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Drive, suite soq

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04^{pay} 6:20 A_M Michael Woods Dean 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Aberdeen Harford 24 Valley Bottom Rd. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 46 Months Hours Min 8/1971963 Maryland 217-90-4559 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Harford Aberdeen Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21001 U.S.A. 24 Valley Bottom Rd. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Concrete Finisher 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Beverly Diane Narvell Roger Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Valley Bottom Rd, Aberdeen, MD 21001 Page 1 and 2 shment of Health a Beverly Diane Woods (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite 1 🗆 Burial 2 🗙 Cremation 3 🗆 Removal from State R.A. Ferris & Co. W.Chester, 12/5/2009 4 Donation any injury 5 Other (Specify) Pennsylvania Sign 1 re 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner al coholy Sequentially list nonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 🗌 Yes 2 No Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

GEORGE

31. Date filed (Month, Day, Year)

S. Union Ave HAURE de Grace Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601

egistrar's Signatur

HEMA

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** December 200 /Medical Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Kesvili If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 ☐ F Yrs August 9, 1925 318-13-7325 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Funeral Director MD acrol Westminste 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3330 21158 nientown USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No Now Y If Yes, Give Year or Dates: 1 ☐ Never Married 22 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 19 th Auto lechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be inthon, 00010 Ine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) downter Department of Health important: if item 27 any injury or other tronce. 339 2 Nestminster Union town \a Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-15-09 Jessup 21. Signatue of Fundral Service Lice se 18437 22. Name and Address of Facility 1535 Approxima e Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage Par **Physician** /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 2No 3 Probably 4 Unknown 1 Tes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 5 Residence 6 Other (Specify) P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00062791 12/2/09 MO 30. Name and address poson who completed cause of death (Item 23a) (Type, Print) Obrecht Ro, Nicholas A. Kozaver, MD Sy kesuille, MD 20784 .

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

Darko

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar/MFND#1perMD, 11–19–09, EMW, MCCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Elein Sam Ayoub Ayoub Apostolakos 2. Date of Death Physician/ 8:05 am Elein 2009 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 6 Winter Garden Court Olney Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Director 219-64-5659 55 Jordan Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 6 Winter Garden Court U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ۾ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced Specify. Completed Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Vice-President Controller Banking permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Suleiman Nimer Ayoub Samira Barbari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Apostolakos - Spouse 6 Winter Garden Court, Olney, Maryland 20832 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 11/17/2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MU070 <u>11800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death リル/も mo Physician disease or condition resulting in death) <u>Glioblastoma Multiforme</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Pregnant at time of death 5 U Other (specify) ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. 1 Yes No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical ompleted filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D43083 November 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Sotos, M.D., 9707 Medical Center Dr., #300, Rockville, Maryland 20850 31. Date filed (Month, Day, Year

Registrar

NOV 16 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#29dperMD, 11–19–09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death November 2009 3:10 P M Carol C. Andrews 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 117 Green Spring Drive Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Days Hours 1 □ M 2 X F 57 Dec. 9, 1951 Washington, DC 579-70-7621 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Anne Arundel Annapolis 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 117 Green Spring Drive 21403 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status African 1 Never Married 2 Married 1 ☐Yes 2A No American Specify 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Christopher, Jr. Beatrice Hume 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4355 Renaissance Dr. #106 San Jose, CA 95134 Charles W. Andrews, Jr. Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory 11/23/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Ave., NW Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) HEOR REBRA Sequentially list conditions if any, leading to immediate Due to for as a consequence off of delivery Year Day ibute to the cause of death? 3 ☐ Probably 4 ☑ Unknown Nere autopsy findings available prior to completion of cause of leath?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

by Funeral

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Mental

h and Mental

permit. Pages 1 and 2 s Department of Health at Important: If item 27 Is any Injury or other trau once.

Pages 1 and 2 should be

Physician/Medical Examiner

physician and attending detached as been signed by 2 should be detach Certification: To Be Completed by certificate has funeral director, ours after death.

neral Director: At filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Metasti Due to (or as a consequent	aric Sience of):	REAST CA	ANCS R	3 CY & A T
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2⊠No 9 □ Unknown	23c. If yes, outcome of pregna 1	death 3 Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	•	,			o use contribute to the cause of death
Fuem	NAZY EM	30602		24a. Was an autopsy performed? 1 □ Yes 2 ☑	
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗍	DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 承Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	
3 Suicide 6 Could not be determined		me, farm, street, fact	ory, office	28f. Location (Street a	and Number or Rural Route Number

To the Hospital within 24 hours a To the Funeral I 20

completely

Hospital

(Check only one)

Medical

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1447494

29d. Date signed (Month, Day, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CANGSTON MONIANE

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certified

egistrar's Signatur

			1 - For State Registrar	State o	f Marylan		artment of I rtificate of			lental H		2009	38939
	Physici	an	1. Decedent's Name (First, Midd							2. Date of D Month		2 2009	3. Time of Death
mar.	/Media	al	Ethel O. Aller 4a. Facility Name (If not institution		mher)		4b. City, Town, o	or Locatio	n of Death	Nov.		2 2009 c. County of Death	2:45 p M
أمي	Examin	ier	Laurelwood Nu		inber/		E1kto		ii oi beaiii			Cecil	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Und	er 24 Hrs Min.	8. Date of B	irth Qay Yea	9. Birth	place (State or Foreign htry) land
	Director		217-12-5783 Usual Residence of Decedent	1□M 2∏F		93 Yrs.				Feb. 2	29,	1916 Mary	land
	/land		10a. State 10b. County	1	10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
	a-fst	ctor	MD Cecil		Ch	esapea	ke City						1 ∏Yes 2 No
	iff th	Dire	10e. Street and Number				10f. Zip Code				10g. (Citizen of What Cour	ntry?
	eath v	Funeral Director	220 Biddle Sti		edent Ever in U.	S 112 1	21915 Was Decedent of I	-lienanio	Origin? (Sp.	acify Vas ar N		SA 14. Race - Americ	can Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		11. Marital Status 1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorced	rried Armed Fo	rces? 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		fYes, specify Cub 1 □Yes 2√ No	an, Mexic	can, Puerto	Rican, etc.)	0-	Black, White,	
21215-0036	2 hour	Completed by	A	Year or D nt's Education	ates.		dent's Usual Occup				16b.	Kind of Business/In-	
215	thin 72 e. an "n: Medi	uple	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	(Give life. I	kind of work done OO NOT use retire	during m d)	ost of worki	ng			
2	filed within Hygiene. other than "		8			Ass	embler					ndustrial	
and	should be filed withir nd Mental Hygiene. marked other than matic event, II E M	Be c	17. Father's Name (First, Middle, Albert Ohrel	Last)					na Kra	(First, Middle	e, Maide	en Surname)	
Maryland	should be and Mental marked o	은	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	a Address (Street				ber. City	v or Town, State, Zig	Code)
Ž	s 1 and 2 soft Health a Item 27 is		Ethel A. Snider		r	160 M	acCauley	Rd.	Conov	vingo,	MD	21918	ŕ
ore	es 1 a of He filtem		20a. Method of Disposition 1 □ Burial 2 □ Cremation	2 Demonstran	20b. F	Place of Dispo	sition (Name of natory or other pla	ce)		Date	1	Location - City or To	
Ē	Pag tment tant: I		4 Donation 5 Other (S		Be		emetery			25,2009	Ch	esapeake	City, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service	Licensee	office.	R 22	Name and Addre T. Foar 59 E. Ma	ess of Fac d and in S	d Gee t Ell	kton, N	íD 2	1921	
			23a. Part 1. Enter the disease of shock, or heart failure. Lis	r complication that of	aused the deatl ach line.								Approximate Interval Between
to.	Physician		Immediate Cause (Final disease or condition	_a. U	END S	MAGE	Den	ريسح	74				Onset and Death
7	/Medical Examiner		resulting in death)	Due to	(or as a consequence		ROIDM	len.	4				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	SCITEM Uras a sunseq		1	pre.)				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c	CVA	~ cer	ebrel v	ASC	· D:	,			
90,	ficate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to	or as a consequ	uence of):			,	J			
58760,	physicate by the b	dical		d									
ŏ	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant		come of pregna							23d. Date of delive	ery
P.O. Box	the death y the atte ched for	Physician/M	in the past 12 months? 1 □ Yes 2 ❷ No 9 □ Unknown		oirth 2□Feta nant at time of c own		Ectopic pregnand Other (specify) _					Month	Day Year
ω, σ.	s that ined b e deta	by Ph	Part II. Other significant conditi	ons contributing to de	eath but not resi	ulting in the ur	nderlying cause giv	en in Pa	t I.	23e. Did	tobacco	o use contribute to the	he cause of death?
ğ	equire en sig ould b	ed b								1 🗆	Yes	2 ☐ No 3 ☐ Prof	pably 4 Inknown
ecc	law re nas be 2 sho	Completed								24a. Wa	psy	prior to co	psy findings available impletion of cause of
<u>=</u>	i: The icate f									per 1 □ Yes	formed?	death? No 1 ☐ Yes	2√2No
<u>=</u>	slciar certif rector	Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:			Oth	or:		(Check only			
ō	ding Physician: The I h. After this certificate ha funeral director, page	n: To	27. Manner of Death	28a. Date	npatient 2 of Injury	28b. Time of	IL 3 LI DOX	470		me 5 ☐ Res 28d. Describe		6 ☐ Other (Special jury occurred	(y)
Ö	ath. r: Aft	atio	L	gation	th, Day, Year)	Injury	M 1 L	κ?]Yes 2	S ¥No				
Division of Vital Records,	i or Atte after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	eet, factory, office			28f. Location City or To	(Street wn, Sta	and Number or Rura are)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the b	best of my kno asis of examina ner stated.	wledge, death	n occurred at the ti vestigation, in my	ime, date opinion, o	and place, leath occur	and due to th	e cause e, date a	(s) and manner as s	stated. o the cause(s)
	To the within To the comple	Mec	29b. Signature and title dicertifie		TOT GILLIOU.		29c. Licens	se numbe	r		29d. [Date signed (Month,	Day, Year)
			► /H/Ea	h ~~			D54	073			2	3 NOV 00	
	5		30. Name and address of person	who completed caus				inc	- :	(,,,,,	_	NE 197	13
	Sta	to	Arlew Stout, 31. Date filed (Month, Day, Year)		E CHN/			105		EUAL		DE 191	1 >
	Sta Registr		NOV 2 4 20	ng A	egistrar's Signa	back	1						

		1	For State Registrar	State of Maryland / Depa Ce	artment of Health and rtificate of Death		ene 2009 38940
	sician edical		1. Decedent's Name (First, Middle, Last) Patricia Ann B	rown		2. Date of Death Month Wavende	Day Year 3. Time of Death
and the same of th	miner	4	la. Facility Name (If not institution, give standard 1412 Fairlakes 5. Social Security Number 6. Sex		4b. City, Town, or Location of Dea Mitchellvill If Under 1 Year If Under 24 Hr	.e s. 8. Date of Birth	4c. County of Death Prince George 9. Birthplace (State or Foreign
Direc	tor	ı	187-42-4909 □ □ Jsual Residence of Decedent 10a. State □ 10b. County	M 2 ☐ F 58 Yrs.		04/28/5	Pa . Country) Pa .
vith the Mary a or 28a-f sh	Funeral Director	1	Md Prince 100. Street and Number		10f. Zip Code 20721	10g	1XXIYes 2 □ No g. Citizen of What Country? USA
be filed within 72 hours after death with the Maryland tial Hygiene. And there than "natural", or Items 23a or 28a-f show and the thing	thy Fineral		1412 Fairlakes 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes X□ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
A D D P P	Completed by			completed) (Give	edent's Usual Occupation kind of work done during most of we DO NOT use retired) Director	F	b. Kind of Business/Industry ederal Government
Maryland 212- d 2 should be filed withir lifth and Mental Hygiene. This marked other than the surrent county.	To Be		17. Father's Name (First, Middle, Last) Drexel Ramsey		Dorot	ame (First, Middle, Ma hy Danie	els
Iltimore, Morit. Pages 1 and 3 artment of Health Ortant: If Item 27 injury or other transmission of the tr	any injury or other traum	2	19a. Informant's Name/Relationship (Typ Dorothy Brown 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Mother 515 moval from State 20b. Place of Dispercemetery, cree Glenwo	ng Address (Street and Number of Park Street (osition (Name of matory or other place) od Cemetery 11 2 Sime and Address Fedliary 1409 Fairlakes	Grindston Date 20 /20/09 W y Service	ne, Pa. 15442 oc. Location - City or Town, State ashington, DC
68760, Cate be executed was physician and physician and the burial-transit			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to line distered cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			Interval Between
D.O. Box 6 at the death certific by the attending p	ian/Me	1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
Records, I alw requires the has been signed	ve predictions		Part II. Other significant conditions cont Piabel Hy, pe		underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
Vita sician: certific	To Be Co	3	25. Was case referred to medical examination 1 ✓ Yes 2 ☐ No	spital: 1 ☐ Inpatient 2 ☐ EP/Outpatie	Othor	1 ☐ Yes 2 [eath (Check only one)	ZNo 1 □Yes 2 □No
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral this	ים פומו	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, stabuilding, etc. (Specify)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred eet and Number or Rural Route Number,
ne Hospita n 24 hours ne Funeral	Medical C		29a. Certifier 1 Certifying Physi (Check only one)	ician: To the best of my knowledge, dealer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ce, and due to the car curred at the time, dat	use(s) and manner as stated. ee and place, and due to the cause(s)
To the to the total of the the the the the the the the the the	N		29b. Signature and title of certifier	v Bherto.	29c. License number		d. Date signed (Month, Day, Year)
	Ch		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type,	Print) Hospital Dri	in Che	Vovember 16 2008 overly may land
Ren	State sistrar	Ì	NOV 16 200	1 / Lucy A. Ma	whit.		/

State of Maryland / Department of Health and Mental Hygiene, 38941 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month Day 200^{Year} **Physician** 06, Nov. 1045 Gwendolyn Maxine Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cheverly <u>Prince Georges Hospital</u> Prince Georges Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Year) 1 □ M 2 1 F Months Days Hours Min 1955 Missie Mill 54 Director 578-74-4769 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or items 23a or 28a-f show Director 1 ¥Yes 2 □ No Capitol Heights Prince Georges illed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA Funeral 606 63rd.Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify ģ 3 ₭ Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 12th. Homemaker 7 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Maxine Smith ပ္ Harrison Woodson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. Geneane Brown/Daughter Capitol Heights, MD 20743 606-63rd. St. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State Nov 12'09Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Avenue, N. W. Wash. DC20011 0278 CC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Luna ner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the hurial-transit Examir Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours after e Funeral Dire 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and tole of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 A 0063688 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Griffin Davis, MD 31. Date filed (Month, Day, Year) Hospital Dr. Cheverly, MD 20785 3001 Registrar's Signatu State NOV 16 Jacks Registrar 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Bhatia November 11,2009 Indra C. 1522 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 16, 1945 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Country) India 1 □ M 2 🗓 F **Director** 218-81-4078 64 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic even. 10d. Inside City Limits 10h County 10c. City, Town or Location 1 XYes 2 No Director Gaithersburg Md. Montgomery 10e. Street and Number 10g. Citizen of What Country? 134 Emory Woods Crt. 20877 India Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2★ No Specify: Asian Indian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Sahijram Bhojwani Rukmani Bhatia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chander Bhatia (Husband) 134 Emory Woods Crt. Gaithersburg, Md. 20877 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory Nov.15,09 Riverdale, Md. 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737 21. Signature of Funeral Service Licensee #670 Showes 5. (2da. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be defached for use as the burish-transit completely filled in by the funeral director, page 2 should be defached for use as the burish-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0068178 П 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Santosh 31. Date filed (Month, Day, Year)

NOV 16 2009

32. Registrar's Signature

Rane, MD. 9901 Medical Center Dr. Rockville, Md. 20850

State Registrar Jason M.

31. Date filed (Month, Day, Year)

Prior, M.D.,

NOV 16 2009

Box 68760,

P.0.

Division of Vital Records,

Registrar's Signature

9901 Medical Center Drive, Rockville, Maryland 20850

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

Director: / within 24 hours a To the Funerai C Hospital

										autopsy performed? 1 □ Yes 2 XNo		ompletion of cause 2 No
	5. Was case referred to medical examiner?							26. Place of Dea	ith (C	Check only one)		
1 Yes 2		No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hol						ome	5 Residence 6	Other (Speci	Mospic
1 🔁	ner of Deat Natural Accident	5 ☐ Pending investigation	1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes 2 □ No	280	d. Describe how injury	occurred	
] Suicide] Homicide	6 Could not be determined	e	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, stree	t, facto	ory, of	fice	28f.	Location (Street and City or Town, State)		al Route Number,
(0	ertifier Check only one)	1 CertifyIng Ph 2 Medical Exam	ıysici niner	an: To the best of my kno : On the basis of examina and manner stated.	owledge, death of ation and/or inve	occurr stigati	ed at t	the time, date and place my opinion, death occu	e, and	d due to the cause(s) at the time, date and	and manner as place, and due t	stated. o the cause(s)

cause(s) and manner as stated. date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Icheu · Kouch

29b. Signature and title of certifier

D63748

11/5/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyn Kouatchou 201 E. University Blvd, Baltimore, MD 21218

State Registrar

cal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38945 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOVEMI36 2000C 155 A M Beck 1na Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTONE MEDICAL CILEN BURNIB ANNE NTE If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Min Director Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important I firem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No orton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21678 15 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Iack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) hucker Be Baltimore, Maryland Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname, ၉ Informant's Name/Relationship (Type, Print) State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State or other place 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending injury work? 2 No Accident Investigation Accident
Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Degistrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 20:10P M Barry L. Brooks NMWHth 18. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 9, 1930 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🖁 M 2 🗆 Months Days Hours 007 26 0939 Director 79 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Prince George Clinton 1 Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5710 Patagonia Court 20735 United States 12. Was Decedent Ever in U.S. Armed Forces?

XXI Yes 2 \sum No If Yes, Give Vietn. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married چ و 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Vietnam "naturaf", White 3 Widowed 4 Divorced Completed Year or Dates. d 2 should be filed within 72 hours a saith and Mental Hygiene. 127 is marked other than "natural er traumatic event, the Medical E) Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Officer Canital Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ R. Llewellyn Brooks Leona T. Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Gregory Johnson 5710 Patagonia Court, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Lee Crematory Nov 20. Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Se Ferry Road, Clinton, . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Examir Physician; The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 the attending IF FEMALE: nse (23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregna Ectopic pregnancy in the past 12 months? signed by the atte Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably page 2 should peen 24b. Were autopsy findings available 24a. Was an was an autopsy performed After this certificate has prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to nedical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After Natural iniury 5 Pending 1 Yes 2 No Investi not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide etermined City or Town, State 29a. Certifier te best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exam asis of ex amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or Certifying 29b. Signat 29d. Date signed (Month, Day, Year) 09 30. Name and addres se of death (Item 23a) (Type, Print

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month

32 Registrars

3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13:43PM 2009 B<u>locker</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Hampshire 55 Director 001-46-9838 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Ħ 10c. City. Town or Location with the Maryland Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 X Yes 2 No Marvland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20603 USA 213 Nobility Ct death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. þ 1 Never Married 2X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Domestic other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever 0 permit, Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic ence. Hilton Sullivan Robert Nora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3213 Nobility Ct.Waldorf Jon<u>athan Blocker/Husband</u> MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/18/09 4 Donation 5 Other (Specify) Metropolitan Alexandria, Va f Funeral Se ce Licensee 22. Name and Address of Facility 21. Signature <u>Adams Funeral Home Pa, Aquasco Md 20608</u> MO1589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a children. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for asia consequence on Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ģ Month Year Pregnant at time of death 2 No 9 Unknown as been signed by the a 9 I Unknown <u>Б</u> Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? certificate ! 1 ☐ Yes 2 ☐ No 2 No Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 M No 1 Tyes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Man er of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending a er death. Director Af 1 ☐ Yes 2 ☐ No М 2 Accider
3 Suicide Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38948 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER 2009 CANDACE GAIL BYRUM 7:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK HOSPITAL MEMORIAL FREDERICK 8. Date of Birth Sept 2, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Year) 957 1 🗆 M 2 🔯 F Months Hours Washington DC Yrs Director 214-72-2762 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2X No Myersville MD Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21773 USA 2740 Canada Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: "natural" 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Δ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Grace Eleanor Summerville Lewis Wilmot Crandall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2740 Canada Hill Road Myersville, MD 21773 Russell Byrum/husband f Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/19/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice Going Hone Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ence Physician NOX Medical resulting in death) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? ie Hospini... in 24 hours after death. **the Funeral Director.** After this certificate انتابيم in by the funeral director, pa Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and ad

31. Date filed (Month, Day

ess of person who completed cause of death (Item 23a) (Type, Print)

Myung Hee Nam, M.D. 400 W. 7th Street Frederick, MD 21701

egistrar's Signature

D35106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 9 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** DO25 M November 14 2009 /Medical Baltin 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner IMOVR S Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 05/03/1927 Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** Days **№** M 2 🗆 F Wash, DC **Director** 577**-**34-2442 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a. State 10b. County 1 ☐ Yes 2 ☐ No **Funeral Director** Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examinar must be a 4500 Vinter Way 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★Yes 2 □ No 1945—
If Yes, Give
Year or Dates: 1952 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced 1952 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Heating/ Air Condition 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert M. Baker Helen Louise Richardson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 4500 Vinter Way Ellicott City, MD 21043 Joan M. Baker - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of the Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 11/17/2009 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LIOVASCOLAN VISCATE Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 🌠 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performe 2 🗆 No 1 ☐ Yes 2 X No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 511 completed, cause of death (Item 23a) (Type, Print) Name and address of person who 0

DHMH 17 Rev 1/2001

Registrar

State

31. Date filed (Month, Day,

Year)

Barker

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 38950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOV. Physician/ Michael J. Byrnes, Jr. 06, 9:51 P M Medical 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 8003 Alexis Court Glen Burnie If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 202-40-3506 1 XM 2 F Months Days NOV. 13, 1948 Maryland Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Glen Burnie 10d. Inside City Limits Director Anne Arundel MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8003 Alexis Court 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. ρ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Frank W. Winne Elementary/Seconday (0-12) College (1-4 or 5+) and Son Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Michael J. Byrnes Marquerite E. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia M. Byrnes / Wife 8003 Alexis Court Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park Nov. Elkridge, MD 2009 Signature of Funeral Solvice Licens 22. Name and Address of Facility Barranco & Sons, Severna Park Funeral Home Severna Park, MD 21146 P.A. 495 Gov. Ritchie Hwy, 23a Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Lis Immediate Cause (Final disease or condition set and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown 1 Yes 2 9 Unknown ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1-Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After t

Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) NOV 13 State 2009 Registrar

			For State Registrar	State	of Marylan		artment of F rtificate of I		Mental Hy	giene Reg. N2 0 0	9 38951
	Physicia	an	1. Decedent's Name (First, Midd	(3, 1					2. Date of Dea Month	ath Day Y	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution	on, give street and n			4b. City, Town, or	r Location of Death	1 1 (4c. County of	* 1
/	LAGIIIII		1122 MAINSAIL I	RIVE				NNAPOLIS			ARUNDEL
	uneral irector		5. Social Security Number 513–20–5241	6. Sex 1 □ M 2 X F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da DECOMBER	th ly, Year) 8, 1927	9. Birthplace (State or Foreign Country) KANSAS
pue	M		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Lo	cation				10d. Inside City Limits
Maryl	rf sho	tor		IE ARUNDEI		,,		POLIS			1 □Yes 2X No
th the	or 28a	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
eath w	S 23a	eral	1122 MAINSAIL I		cedent Ever in U.	6 112 1	Mas Decadent of H	21403	pocify Vos or No		D STATES - American Indian,
d حاركات المالات المالية الما	or realing and when any letter and any state of show them 23a or 28a-f show other traumatic event, the Madical Everying the rediffied at	Ď	11. Marital Status 1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed F rried 1 _Yes	Forces? 2 ∑ No Bive		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🔣 No	Specify:	o Rican, etc.)		White, etc.
3-C	natura fical B	Completed		nt's Education est grade completed	1)	(Give	dent's Usual Occup	during most of wor	king I	16b. Kind of Busi	ness/Industry
within A	than "	Jdwc	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. I	DO NOT use retired UIDANCE C	d) -		EDII	CATION
filed A	other /ent,	Be Co	17. Father's Name (First, Middle		, i	G	OIDANCE C			Maiden Surname)	
aryiand should be file	arked artic ev	70 E	WILLIAM GARRET						CE HAY		
Mar d2sh	Tism traum		19a. Informant's Name/Relation CANDACE A. RIDO		ITED					er, City or Town, Si	tate, Zip Code) ARYLAND 21035
nore, m ages 1 and 2	t: If item 2		20a. Method of Disposition 1 ↑ Burial 2 ☐ Cremation	3 ☐ Removal from	20b. F	Place of Dispo	sition (Name of matory or other place NATIONA	>	Date MBER 7,	20c. Location - C	ity or Town, State
partimo	Important: If item 2 any injury or other once.		4 □ Donation 5 □ Other (and 21. Signature of Funeral Service))))))))))))	METERY C	2. Name and Addre	ss of Facility FE	T.I.OUS. I	IELFENBET	N, VIRGINIA N AND NEWNAM 814 BESTGATE
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	r complications that	caused the deat						Approximate Interval Between
Phy	/sician		Immediate Cause (Final disease or condition		VATIA	Car	cer				Onset and Death
	ledical aminer		resulting in death)	Due to	o (or as a conseq	uence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conseq	uence of):					
ecuted	and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		-					
cate be executed	physician and the burial-transit		resulting in death, Last	Due to	o (or as a conseq	uence or):					
00/ tificate	ng phy∉ as the	ledical		d							
UNISION OF VICAL RECORDS, P.O. DOX of To the Hospital or Attending Physician: The law requires that the death certifications of per death.	as been signed by the attending l 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna e birth 2 ☐ Feta egnant at time of o known	II death 3	☐Ectopic pregnanc ☐Other (specify)	Эy		23d. Date Mont	
v requires that	n signed by Ild be deta	ρ	Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	/	oute to the cause of death?
The law rec	ate has bee oage 2 shor	Completed							24a. Was autop perfo 1 □ Yes	osy pri ormed2 de	ere autopsy findings available for to completion of cause of ath? ☐ Yes 2 ☐ No
VICAL ician: 1	After this certificate h funeral director, page	Be C	25. Was case referred to medical examiner?				041		ath (Check only c		
Phys	r this or	<u>۲</u>	1 Yes 2 No 27. Manner of Death		Inpatient 2 e of Injury	ER/Outpatier 28b. Time o		4 LI Nursing F		dence 6 Other	
SION tending	r: Afte	ation	1 Natural 5 ☐ Pendi 2 ☐ Accident invest		onth, Day, Year)	Injury		kí? Yes 2. □No		,	
al or Atte	I Directo	Certification: T	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 206. Flat	ce of Injury - At he ding, etc. <i>(Speci</i> i	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
ne Hospit	To the Functal Director: completely filled in by the	Medical (29a. Certifier Certify (Check only one) Certify		ne best of my kno basis of examina inner stated.	owledge, deat ation and/or in	h occurred at the ti	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and man date and place, an	ner as stated. nd due to the cause(s)
To th	To the	Ž	29b. Signature and title bicertifi	er			29c. Licens			1	(Month, Day, Year)
			OO Name of	MO		n 025\ /T	067	L72		11/11/0	14
			30. Name and address of person	1 900 8	Ses- Gat	RI	Suite 3	00 Ar	1119-0-	Mo	2140)
	Sta Registr		31. Date filed (Month, Day, Year NOV 13	2009 L	Registrar's Signa	ature . Sa	Nes .		,		

State of Maryland / Department of Health and Mental Hygiene 38952 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Pui Ching Cheung 11 15 2009 3:30 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Manor Care Nursing Home Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Oay, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs. Director 92 6/17/1917 214-11-4470 China Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director NONE DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 5123 44th St NW 20016 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Chinese þ 3 X Widowed 4 Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Ping Nan Cheung Sun Ying Pan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wong/Power of Attorney 5123 44th St NW Washington DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1 Department of H Importent: If Ite any injury or ot ance. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2009 Alexandria VA Metropolitan Crem. 21. Signature of Funeral Service Licenses 400 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Brain Tumor /Medical Due to (or as a consequence of): Examiner Left Renal Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit Hypothyroidism nding physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Osteoarthritis IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes 2X No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature ar 29d. Date signed (Month, Day, Year) title of certifie D-20274 11/16/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti K. Vohra, 7710 Bradley Boulevard Bethesda MD 20817

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 20 2009

Division of Vital Records, P.O. Box 68760,

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0250 am bvember 14,2009 Theresa Cherry Norma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BrookeGrave Assisted Living - The Woods 1616 Spring Sandy Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Min. 1 □ M 2 🖾 🔭 8, 123-05-6543 88 Feb. 1921 New York Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experiment has the notified at 1 □Yes 2 TNo Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11045 Dorsch Farm Road 21042 USA Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 🖸 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bailie Marie Griffin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Joseph F. Cherry, III/Son 11045 Dorsch Farm Road, Ellicott City, MD 21042 injury or other Department of Heal Important: If item 2 any injury or other once. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 2009 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ncterial pneumonia Jaus **Physician** pacterial disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year for in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 □ Yes director, page 2 should Be Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 ☐No certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assisted 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

P

State Registrar 31. Date filed (Month, Day, Year)

NOV 19

Slade School Road Sandi

address of person who completed cause of death (Item 23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De 7:30a No 17, 2009 **Physician** Cho Clara Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 / 15 / 1919 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, Funeral Months Days Min. 1 □ M 2 □ F Hours 90 475-80-4314 Director Korea Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "hadical Exercises Inside at Wheaton MD Montgomery Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 4011 Randolph Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Asian þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygid Important: If Item 27 is marked other I any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sung Hoon Choi Kyung Hoon Park ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3492 Sweetberry Court Oakton, Va. 22124 Kyuwon Yu/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ © remation 3 ☐ Removal from State 11/19/2009 Silver Spring, Md Gate of Heaven 4 ☐ Donation Other (Specify) 21. Signature of PHITTIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's disease 6yrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 6yrs Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit 7yrs Multiple joint arthritis and Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🛂No Month Day Year 5 Other (specify) P.0. the detached 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2X No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? re Hospital or Attending P n 24 hours after death. ie Funeral Director: After t 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 18, 2009 D0021033

State Registrar

NOV 19 2009

13000 Ave. Georgia Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Byoung K Lee MD

31. Date filed (Month, Day, Year)

Silver Spring, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38955 Certificate of Death 1. Decedent's Name (First, Middle, Last)
Ernest McDonald 2. Date of Death Caudill Physician/ November Day 5, 2009 2:35 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens of Tuckerman Lane Rockville Montgomery Social Security Number 245–14–2556 7. Age (In yrs. last birthday) 89 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days Hours Min. Feb. 12 Year) 1920 Director North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Montgomery 1 ☐ Yes 2 K No Kensington 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe Funeral items 23a 10617 Drumm Avenue 20895 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married ģ Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: Completed Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ital Hygiene. ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Country Store Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic evel ပ Sherlie Caudill Mamie Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Rachel Caudill/Wife 10617 Drumm Avenue, Kensington, MD 20895 Baltimore, t; If item Date 20, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Ę, 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Nov. Important; If any injury or once, Mt. Carmel Cemetery 4 Donation 5 Other (Specify) 2009 Sunshine, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spr. MD 20901 23a. Part 1. Enter the Mease, or complications that caused the Matt. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Heart Disease Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Exam attending physician and for use as the burial-transit Bladder Cancer Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Anemia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Day Year ate has been signed by the a page 2 should be detached it Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease, Dementia Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2x No Director: After this certific I in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 K No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at I or Attending I after death. 1 Natural 5 Pending injury work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 🗌 Homicide determined Hospital Medical 29a. Certifier 1 💆 Certifying Ahysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Ex niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying (three Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D53691 November 16, 2009

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who do

NUV

MD

2009

Ajay Reddy,

3200 Tower Oaks Blvd., #110, Rockville, MD 20852

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38956 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Cockrell Denise 5:35 AM Novembor 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Cify. Town, or Location of Death 4c. County of Death Baltimore Baltimore of Baltimore Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 12 F Months Days Hours Min. Sept. 28, 1955 228.84.3763 **Director** Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits by Funeral Director Baltimore MDBultmore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21244 3701 Twin Lakes Ct Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Circuit Elementary/Seconday (0-12) College (1-4 or 5+) Scanning State Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Virginia Lee Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Birminaham Ave. Apt C Norfolk, VA 23505 Pamela Cockrell Brunswick (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11.21.2009 Lottsburg, VA ■ Donation 5 ☐ Other (Specify) Zion Baptist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Berry O. Waddy Funeral Itome VA 22503 6784 Mary Ball Rd ancuster. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear sailure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Inal Physician/ Hodokins Non disease or condition resulting in death) Medical Due to (Ir as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Thrombocytopenia 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has be completed filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2: No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Abraham RES 000 MBBS

Registrar DHMH 17 Rev 7/2009

State

Krell

3

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MABS

ABRAHAN

31. Date filed (Month, Day, Year)

NOV 2 3 2009

November

Battimore

12,2009

2401 W. Belvedere Av. MD2121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9 1 - For State Registrar 38957 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2009 11:20 pm Lien Dana Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1907 Bishop Castle Drive Olney Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Country) Vietnam 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🏻 F 12/24/1919 Director Yrs 408-33-0357 89 Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10b. County and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** notified 1 Yes 2 X No Maryland Olney Montgomery 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? must be 23a 1907 Bishop Castle Drive 20832 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: If Yes Give Specify: Completed 3 X Widowed 4 Divorced Asian th and Mental Hygiene. ?7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Huy Dang Vi Tuong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Larry T. La - Son 5510 Muncaster Mill Rd.. Rockville. MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) George Washington Cem. 11/15/2009 Adelphi. MD Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Sign e of unera 11800 New Hampshire Ave., Silver Spring, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical Examiner Examine attending physician and for use as the burial-tran by Physician/Medical Medical Certificate: To Be Completed

P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificant To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by t

Baltimore, Maryland 21215-0036

disease or condition	septicemia			_ 22 days
resulting in death)	Due to (or as a consequent	e of):		
Coguantially list conditions	Renal Insu	Miciency		22 days
Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events	Dun to (or as a consequence			
resulting in death) Last	Due to (or as a consequence d.	e of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3 Dectopic pregnancy	23d. Date of o Month	delivery Day Year
Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Diabetes Mell	itus		1 □ Yes 2 🗓 No 3 □	Probably 4 🗆 Unknown
Hypertension			autopsy prior t performed? death	autopsy findings available o completion of cause of? Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death		
1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3 DOA Other: 4 Nur.	sing Home 5 🛛 Residence 6 🗌 Other (Sp.	ecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	b. Time of injury at work? M 28c. Injury at work? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \subseteq \text{ N}	28d. Describe how injury occurred	551,77
3 Suicide 6 Could not 4 Homicide determined		farm, street, factory, office	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
(Check 2 ☐ Medical Exar only one) 3 ☐ Certifying Nu	niner: On the basis of examination an	d/or investigation, in my opinion, death occ	ace, and due to the cause(s) and manner as surred at the time, date and place, and due to the tand place, and due to the cause(s) and manner	e cause(s) and manner stated.
29b. Signature and title of certifier	, /	29c. License number	29d. Date signed (Mon	nth, Day, Year)
Naws br	rdul	D45956	November	10, 2009
30. Name and address of person who	completed cause of death (Item 23)	a) (Type, Print)		
Dawn Broderick,	M.D., 18109 Pri	nce Philip Dr., Olv	rey, Maryland 20832	
31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year)</i> NOV 16 20	3. Registrar's Signature	parles.		
	(ORIGINAL		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38958 State of Maryland / Department of Health and Mental Hygien 2 1 1 9 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 22:43 M November 16,2009 Dambreville Laurette 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Cheverly Prince Georges Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV • 29 , 1932 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 1 ☐ M 2 💢 F 76 Haiti 578-74-6895 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1XYes 2 No MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 602 Evening Star Place 20721 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Claire Fonrose Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
602. Evening Star Place
Bowle, MD 20721 19a. Informant's Name/Relationship (Type, Print) Marie C. Penn/Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11/23/09 Beltsville, MD 21. Signature of Euneral Secrete License 22. Name and Address of Facility AGEE/MCKINNON Funeral Service MD0996 3821 14th Street, NW, Washington, DC 20011 Approximate Interval Between On t and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on lash line. Immediate ause (Final disease or condition resulting in death) Due (ov as a consequence of) Sequentially list conditions, ir any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Department of Important: If any injury or once.

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

al Hygiene.

.. Pages 1 and 2 should be filed v tment of Health and Mental Hygis tant: If Item 27 is marked other t jury or other traumatic event, ID

Completed by Funeral Director

Be ၉

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-transit use as t ģ icate has been significate page 2 should b

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

Be Completed by Physician/Medical Examiner To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

autopsy performed? 20 NO 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ MG Certification: To 1 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madidal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

(Check only

29b. Signature and

title of g

31. Date filed (Month, Day, Year) 32 Registrar's Signature 20

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

Flyg

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20, William Elmer Dresher 3:00 PM November 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 2 M 2 □ F Months Days Hours Min. 217-01-8747 97 March 5, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD St. Mary's Lexington Park 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20633 Poplar Ridge Road 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 A Married 1 ☐Yes 2 🖺 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dresher Margaret Boyce Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Dresher (Son) 44203 Maidens Court, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Charlotte Hall, MD 21. Signature of Funeral Service Lic piscer

Danielle Ward 101403 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a project. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2□No 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, Hospital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

death

permit. Pages 1 and 2 should be filed within 72 hours after dea Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item-any Injury or other traumatic event ***-.**

Physician /Medical Examiner

burial-tran

the

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attending physician

detached

signed I be det

has been

certificate

After this funeral

page 2 should Completed

n 24 hours after death.

le Funeral Director: Af the within To the

State Registrar

DHMH 17 Rev 1/2001

Dr. Manoj Panwala, M.D., Charlotte Hall, MD 20622 31. Date filed (Month, Day, Year)

NOV 2 4 2009

(Check only one)

29b. Signature and title

30. Name and address of



who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

11 - 23-2 009

State of Maryland / Department of Health and Mental Hygier

		•	For State Of IVIS		rtificate of Deati	h	Reg. N	0000	38960
	Physicia		1. Decedent's Name (First, Middle, Last) Jeffery Neal Dinges				Date of Death Month Ovember	Day Year 22, 2009	3. Time of Death 8:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locatio		4	4c. County of Death	1 a
	Funeral Director		38020 Mt. Wolfe Road #A 5. Social Security Number 6. Sex 7. Ag 5. TSI M 2 □ F 7. Ag	e (In yrs. last birthday) 52 Yrs.	Charlotte H If Under 1 Year If Und Months Days Hours	ler 24 Hrs. 8	Date of Birth (Month, Day, Yea	St. Man 9. Birth Cou 1957 Mis	place (State or Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2█ No
	r 28a-f s	Director	Maryland St. Mary's 10e. Street and Number		Charlotte H	lall	10g.	Citizen of What Cou	
	leath with	Funeral D	38020 Mt. Wolfe Road #A	Ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexic	622 Origin? (Speci	ify Yes or No-	USA 14. Race - Ameri	
036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dieal Experient must be rediffed at	by	1 ★ Never Married 2 Married 1 ★ Never Married 2 Married 3 ₩ Widowed 4 Divorced Armed Forces? 1 ★ Yes, Give Year or Dates:	No	1 □Yes 2⊠No <i>Speci</i>			Black, White, Specify: Wh	ite
21215-0036	ithin 72 ho ne. han "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or secondary)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired) S Department		P	. Kind of Business/Ir epco/Mirar	·
Z D	filed w I Hygie other ti ent, th	Be Co	12 17. Father's Name (First, Middle, Last)	Deore			First, Middle, Maic	den Surname)	
ylan	ould be Menta arked atic ev	To B	Harold Dinges				eila E. I		
Mar	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)	5.01	ng Address (Street and Nur Huckleberry				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Marical Exercities must be rediffied at once.		Heather A. Dinges / Daugh 20a. Method of Disposition 1□ Burial 2 ☑ Cremation 3 □ Removal from State 4□ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place) an Crematory	November 200	te 20c	Location - City or Texandria, Vi	own, State
Balti	permit. Departm Importa any Inju		21. Significant of Fugeral Service Lightsee 21. Significant of Fugeral Service Lightsee 22. Significant of Fugeral Service Lightsee 23. Part I. Enter the disease, or complications that cause	ner	2. Name and Address of Fa Mattingley-Gar P.O. Box 270	diner Fu Leonardt	own, MD 20	650	Approximate
	Physician and bulking the print transit the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of): a consequence of): a consequence of):	tie Toud	COVA	odan	Union	Onset and Death
P.O. Box 6	eath cerl attendin for use	Physician/Me		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
	juires that t n signed by ild be detac	δ	Part II. Other significant conditions contributing to death	out not resulting in the t	underlying cause given in Pa	art I.		cco use contribute to	20
of Vital Records		Completed					24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No Hospital: 1 □ Inpat	ient 2 ☐ ER/Outpatie			(Check only one)	e 6 ☐ Other (Spe	cify)
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Accident (Month, D	ury 28b. Time	of 28c. Injury at	2	8d. Describe how		
Division	tal or Atter s after des al Director ed in by th	Certifica	4 ☐ Homicide determined building, ∈	jury - At home, farm, st tc. <i>(Specify)</i>			City or Town, S		
	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical (29a. Certifier (Check only one) Check only one) Certifying Physician: To the besing and manner sand	of examination and/or i	ath occurred at the time, dat investigation, in my opinion,	te and place, a , death occurre	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifie		29c. License numb	ber	29d	. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)	581		4/2	3/09
dl	ر		William D. Boyd, II, M.D. 253	65 Pt. Lookou		dtown, M	D 20650		
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	back				

DHMH 17 Rev 1/2001

			partment of Health and N ertificate of Death		ZHIU KKUK	ı
Physic	cian/	1. Decedent's Name (First, Middle, Last)	stimodic of Bodin	2. Date of Death	3. Time of Death	
	dical	- Joseph Diezer	4b. City, Town, or Location of Death	November	Day, 2009 /0 23 PN 4c. County of Death	1
1	Ţ	38 Sunset Drive	Severna Park		Anne Arundel	
Funer Directo		5. Social Security Number 216–42–0827 6. Sex 1 M 2 □ F 66 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 06,	9. Birthplace (State or Foreign Country) 1943 Maryland	n
and show	١	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits	
e Maryli r 28a-f notified	Direct	MD Anne Arundel Severna			1 ☐ Yes 2 🔯 N	Ю
with the s 23a o	eral	10e. Street and Number 38 Sunset Drive	10f. Zip Code 21146	10g.	Citizen of What Country? USA	
IANG 27275-UU36 be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Z1Z15-UU36 within 72 hours after giene. er than "natural", o , the Medical Exam	omplet	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	ng	b. KInd of Business Industry Financial		
filed wit al Hygie d other went, tt	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Iryland build be filed and Mental Hy marked ott	ြို			Elizabeth		_
hd 2 shou ealth and m 27 is m		Margaret Ditzel / Wife 38	iling Address (Street and Number or Rura Sunset Drive Sever	na Park,	y or Town, State, Zip Code) MD 21146	
EaltImore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es			ematory or other place) NOV.	42	c. Location - City or Town, State Baltimore, MD	
Depar Depar Impor	ouce.	21. Signature of Funeral Service bicensee	22. Name and Address of Facility Barranco & Sons, P. 195 Gov. Ritchie Hw	A. Severn	na Park Funeral Home na Park. MD 21146	
Physician	4.5	23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death	٦
Medica	al	disease or condition resulting in death) a. ue to (r as a consequence of the consequence	611001A31UMA	אווטווון	orme	
	iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)	rillation	· (45	_
ecuted and I-transit	zami	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):	r dyschyth	ma	40	
rate be executed physician and sthe burial-transit	edical Examiner	d				
To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
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/sician; s certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check			
nding Phy ath. r: After thi	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury		8d. Describe how in	e 6 Other (Specify)	
tal or Atters after de al Directo	al Certif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
the Hospi hin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check only one) 1	stigation in my opinion, death occurred at a	the time date and pla	aco, and due to the cause/s) and manner state	ed.
with Cor		29b. Signature and tipe of tertifier builty mo	29c. License number 054749	2 29d. I	pate signed (Month, Day, Year)	
45			ing Crossroads,	Baltin	oce, ml Zizza	
St Regist	ate trar	31. Date filed (Month, Day, Year) NOV 13 2009 32. Régistrar's Signature	back			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per Dr. G898 12/23/09 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 38962 Reg. No.2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Milene Mae Ely Nov. 22 2009 7:53 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 255 Woods Road Ceci1 E1kton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 □ M 2 □ xF Months Days 221-16-0242 81 Yrs. Director 24, 1928 Colorado Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Modical Exercitive roughed at Director 1 ☐ Yes 2 ☑ No MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 Woods Road 21921 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withir Health and Mental Hygiene. Health Administrator Public Health 7 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milo M. Clark Ila Lee Ollinger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Sharon Schnatz/ daughter 245 Woods Road Elkton, MD 21921 : If Item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Delaware Veteran's Memorial Cemet 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Cemetary Bear, Delaware 22. Name and Address of Facility
R.T. Foard and Gee
259 E. Main Street Elkton, MD 21921 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate of Vital 1 ☐ Yes 24 DXNo 1 ☐ Yes 2 □ No Physician: 25. Was ease referred to medica 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

Day, Year) 2 4 2009 31. Date filed (Month, Registrar

John R

Mulvey,

(Check one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

111 West High St. Suite 309

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number

Elkton,

29d. Date signed (Month, Day, Year)

MD 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38963 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 Linda Jeanne Edwards 1:40 am November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 10305 Brookmoor Drive Silver Spring Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours 167577948 North Carolina Director 218-56-3272 61 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10305 Brookmoor Drive 20901 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. Completed by 1 Never Married 2 X Married Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be mea with permit. Page 1 and 2 should be mean. Department of Health and Mental Hygiens. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence S. Overton Jeanne Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Joseph Edwards - Spouse 10305 Brookmoor Dr., Silver Spring, MD 20901 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🛭 Removal from State 11/17/2009 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rindle Funeral Home, MO#1070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Liver Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🕱 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Kashis Firozvi,

31. Date filed (Month, Day, Year)

D0064983

2101 Medical Park Dr., Silver Spring, Maryland 20902

November 11. 2009

		For State Registrar	State	of Marylar		artment rtificate			and Me	ental Hygi	ene g. No.	09	38964
Dhuaiais		1. Decedent's Name (First, Middle								2. Date of Death Month		Year	3. Time of Death
Physicia /Medic	al .	ROBERT	RAY		NSTEIN					November			8:50p. M
Examin	er	4a. Facility Name (If not institution,	-			4b. City, To			of Death			unty of Death	
		Homewood at Cr	umland F	7. Age (In yrs	last hirthday)	If Under 1	der:	ick If Under:	24 Hrs.	8. Date of Birth	Fr	ederic	. K nplace (State or Foreign
Funeral Director		220-28-2966	1 M 2 □ F	81	Yrs.		Days	Hours	Min.	eb. 6,	Year) 1928	Coi	yland
		Usual Residence of Decedent											
nylan how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. fnside City Limits
Ba-f s	cto		erick		Freder								1 Yes 2 No
vith th	Dire	10e. Street and Number 7351 Willow Roa	d Cott	age 11		10f. Zip C	217	702		10	g. Citizer	of What Co	untry?
ite; Intally fall to Z. 1.Z. 1.Z. 2.Z. 2.Z. 2.Z. 2.Z. 2.Z. 2	Funeral Director	11. Marital Status		cedent Ever in t	IS 13	Was Decede			nin? (Spec	ofy Yes or No-	14.	Race - Amer	ican Indian.
fter d	Fun	1 ☐ Never Married 2 ☑ Marri	Armed F	orces? 2 No live					, Puerto R	ofy Yes or No- lican, etc.)		Black, White	e, etc.
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Y es, G Year or	Dates: 46-	48	1 ☐ Yes 2	No.	Specify:			Sp	ecify: W	hite
72 ho	Completed	15. Decedent (Specify only highes	s Education)	16a. Dece	dent's Usuat kind of work DO NOT use	Occupa done d	ation during mos	t of workin	g 1	6b. Kind	of Business/I	ndustry
ithin al	nple	Elementary/Secondary (0-12)	1	(1-4or 5+)	Custon						icin	oca Ma	chines
tygie v		12 17. Father's Name (First, Middle, I	201)		Custon	iel bei	LVIC			(First, Middle, M			Cillies
d be f	Be C	Walter Ray		oin						Marie	Doma		
should Me	ဥ	19a. Informant's Name/Relationsh		E111	19b. Maili	ng Address (Street a			Route Number,			lip Code)
IVIC nd 2 :		Betty C. Falken	stein/wi	fe	7351	Willow	w Ro	oad,	Cotta	ge 11,	Fred	erick,	MD 21702
partition, permit. Pages 1 and Department of Heeli Important: if itam 2 and injury or other		20a. Method of Disposition			Place of Dispo	sition (Name	e of ner place	e) !	Da	ate 2	0c. Locat	tion - City or	Town, State
Page Page net of int: if		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		Sm	-	-			ov.30	,2009 St	niths	sburg,	Maryland
mit. partir porta y inju		21. Signature of Funeral Service I	icensee		2	2. Name and	Addres	s of Facilit	ty	504	Main	Stree	t
0 88558		Jod te	tell		Ri	cketts	s Fu	mera.	1 Hom	e Myer	sv11.	le, Ma	ryland 21773
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/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):								1 40)
3	-	Sequentially list conditions, if any, leading to intrinsidate	b. 101	7al /	autice of):	١							35
nsit ed	nin	Cause (Disease or injury	a	nema	2								241
be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	C	o (or as a conse	quence of):								V -
cate be executed physicien and the burial-transit	cai		d										
The law requires that the death certificate sie has been signed by the ettending phys page 2 should be detached for use as the		IF FEMALE:											-
ath cer tendir	an/l	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregr birth 2 Fe	tal death 3[☐Ectopic pre					230	 Date of definition 	ivery Day Year
w requires that the death certifical been signed by the ettending of should be detached for use as the	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unk	nant at time of nown	death 5[Other (spe	cify)						,
that if		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying car	use give	en in Part I		23e. Did tob	acco use	contribute to	the cause of death?
requires een sign	d by		-							1 □ Ye	s 2 1	No 3□Pr	obably 4 Unknown
w req	lete									24a. Was an		24b. Were au	topsy findings available
The la	Completed									autopsy perform	ed?	prior to death?	completion of cause of
to per le	BeC	25. Was case referred to medical		70		W. C. C. C. C. C. C. C. C. C. C. C. C. C.		26. Pface	e of Death	Check only one			
OI VILA Physician: rithis certific	2	examiner? 1 ☐ Yes 2 No			☐ ER/Outpatie			4 NU	ursing Hon	ne 5 🗌 Reside	nce 6[Other (Spec	cify)
oding Ph th. : After this funeral		27. Manner of Death 1 X Natural 5 ☐ Pendin	9	of Injury onth, Day Year)	28b. Time of Injury		c. Injury Work			8d. Describe ho	w injury o	occurred	
Attending or death.	icat	Accident investig	ot be	ce of Injury - At	homo farm of	M Cost (setes)		Yes 2 □		19f Location (Str	eet and h	Jumber or Ri	ıral Route Number,
To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director, after this certificate has completely filled in by the funeral director, page 2.	Certification;	4 ☐ Homicide determ	ned buif	ding, etc. (Spec	cify)	reet, ractory,	Unice			City or Town		Va.//20/ 0/ / 10	
spita sours neral		29a. Certifier Certifyin	g Physician: To the	ne best of my kr	nowledge, dear	h occurred a	it the tim	ne, date an	nd place, a	nd due to the ca	use(s) ar	nd manner as	stated.
n 24 h	edicai	(Check only one)	Examiner: On the and ma	basis of exa <i>m</i> ir nner stated.	nation and/or in	vestigation, i	in my o	pinion, dea	ath occurre	ed at the time, da	te and pl	ace, and due	to the cause(s)
To the within To the comp	¥.	29b. Signature and the of certified	000	1				e nu <i>m</i> ber		58	d. Date s	signed (Mont	h, Day, Year)
1		1 obet a	. Jay	mann	ノ	1)—/	397	/		11/0	29/0	9
15		30. Name and address of person Robert L. Kaufm	./	-			t. F	rede	rick.	Marvla	nd 2	1701	
Sta	te	31. Date fifed (Month, Day, Year)	32.										
Registr	ar	DEC 07 200	19 Ceres	N B.	A CHEST						<u>-</u>		

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			For State Registrar		State of Ma	aryland	-	artment of I <i>rtificate of</i>				gieng Reg. Nå	711114	389	65
	Discontinu			ıme (First, Middle, La							2. Date of Dea			3. Time of	_
4,	Physici /Medio	cal		ancy)		Froh)		word	200	d'900	*	OP M
R	Examir	er	4a. Facility Name	Hookins (It not institution, given	re street and number)	gra.	enter	4b. City, Town, o				4c. County of Death			
	Funeral		5. Social Security	Number 6.	Sex 7. Ag	e (In yrs. l	ast birthday)	If Under 1 Year Months Days		er 24 Hrs. 8	B. Date of Birt (Month, Da	h y, Year,	9. Bi	rthplace (State o	or Foreign
	Director		503–26–1 Usual Residence	1311	1 L M 2 A F	32	Yrs.			N	ov. 14,	1920	6 So	uth Dakot	a
	ryland how	_	10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside Ci	
	Ba-f s	Director	Maryland		gomery		Silver					10- 0			2 🔀 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Evaninar mast burrofflind at	II Dir	10e. Street and N	Number Renfrew Roa	đ			10f. Zip Code	901			USZ	itizen of What C A	ountry?	
	death	Funeral	11. Marital Status	5	12. Was Decedent I	Ever in U.S	S. 13.	Was Decedent of I If Yes, specify Cub		Origin? (Spec	ify Yes or No-		14. Race - Am Black, Whi		
36	s after , or ite			arried 2 Married	1 □Yes 2 🛣	10		1 □Yes 2 🛣 🗷o			iouri, otor,		Specify:		
215-0036	2 hour atural	Completed by		15. Decedent's E	Year or Dates:	Т	16a. Dece	dent's Usual Occu	pation			16b. H	Kind of Busines	White s/Industry	
215	within 7; jiene. r than "n In Medi	nple		ecify only highest gr econdary (0-12)	College (1-4or 5	+)	life.	kind of work done DO NOT use retire	d)	ost of working	'				
d 21	should be filed within and Mental Hygiene. is marked other than "aumatic event, I'm Mex	S	17 Father's Nam	ne (First, Middle, Lasi	4		Med	ical Techn	T	other's Name (First. Middle.	Maidei	Health C	are	
lan	ld be f lental ked o	To Be	Robert V	•	,				l .	her Moos			,		
Maryland	2 shou and N is mar	-	19a. Informant's	Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Nui	nber or Rural	Route Numbe	er, City	or Town, State,	Zip Code)	
	l and dealth			. Froh/Son		Joh B		Bernard St		Alexand			L4 .ocation - City o	r Town State	
Baltimore,				•	Removal from State			osition (Name of matory or other pla aven Cemete		Nov. 200	16,				-ma
altir	permit. Page Department of Important: If any injury or once.		L	Funeral Service Lice			2	2. Name and Addre	ess of Fa	cility				ing,Maryl	anu
8	permi Depa Impo any is) Ci	rober of	Cole			Francis J. 500 Univers	sity D	Blvd. W.	, Silver	: Spi	ring,MD 2		
			23a. Part 1. Ente shock, or h Immediate Caus		plications that caused one cause on each lin	the death	n. Do not en	ter the mode of dyi	ng, such	as cardiac or	respiratory a	rrest,		Approximat Interval Bet Onset and	lween
	Physician /Medical		disease or cond resulting in deat	ition	aDue to (or as	a consequ	ieuch u.	RITC						www	62
1	Examiner		Commentation		b Chro	210	Lin	nhaci	ti	CL	euk	60	ii Ci	4605	S
2	ed sit	iner	Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve	derlying	Duc to (or as	а өм юнци	unee ury	7	7.					7	
D.	execut n and al-tran	Examiner	that initiated eve resulting in death	nts n) Last	c. Roso Due to (or as	a consequ	ience of):	4 tail	112	Q				Last	<u> </u>
68760,	icate be executed physician and s the burial-transit	edical		•	d. Pae	4	$\overline{\omega_i}$	<u> </u>						conti	V2.
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:		000 16.000 00400000	(b 1/18) a								-	
Вох	feath certific attending p	Physician/M	23b. Was deced	12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[☐ Ectopic pregnand ☐ Other (specify) _	су			Ì	23d. Date of d Month		Year
P.O.	uires that the de signed by the d be detached to	hysi	1 □Yes 9 □ Unknov		9 Unknown						1				
	res tha	2			contributing to death be			nderlying cause gi	ven in Pa	rt I.	23e. Did to			to the cause of o Probably 4□	
Sorc	w requir s been si should I	Completed		-	Ischo	MIC	1								
Rec	he law e has	duc	Herr	562 EU	aphalis	12				_ 		sy rmed?	prior to death?		cause of
ital	iclan: The certificate ector, pag	BeC		ferred to medical					26. PI	ace of Death		2, N ne)	0 1 ⊔ Y €	s 2 No	
of Vital Records,	or Attending Physician: after death. Director: After this certifici		examiner? 1 ☐ Yes 2					III 3 LI DOA					6 ☐ Other (Sp	ecify)	
ou o	ding F h. After funera	Certification: To	27. Manner of De Natural 2 ☐ Accident	5 Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	Wo	iry at rk? ∐Yes 2		3d. Describe I	now inju	ury occurred		
Division	Atten ector: by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b	e 280 Place of Inju	ury - At ho	me, farm, st	reet, factory, office			3f. Location (S City or To			Rural Route Nur	nber,
Ö	ital or irs afte ral Dir led in	Cert	4												
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	1 ☑ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examinat	wledge, deat tion and/or in	th occurred at the to estigation, in my	ime, date opinion,	e and place, a death occurre	nd due to the d at the time,	cause(date ar	(s) and manner nd place, and d	as stated. ue to the cause(s)
	To the within to the comple	Me	29b. Signature	nd title of certifier	05		~	29c. Licen	se numb	er		29d. D	ate signed (Mo	nth, Day, Year)	
	5		• (NI	-	n		\square	04	138	3	No 1	rember	7, 200	7
			30. Name and ad	ddress of person who	nous of d	eath (Item	23a) (Type,	Print) 55	25	Hopki	ing I	302	122 iew	9,200 Circle	
	Sta	te	31. Date filed (M		-33. Registr		ture		111	V CO V	1 010			<u> </u>	
	Registr	ar	N	10V 16 201	19 /2	, 1	Mac	ممير							

38966

Physician
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, the Medical Expression and the matter and the matter and one of the traumatic event, the Medical Expression and third at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
sici		Harvey	Geige	r Jr	. Nov	27, 2009 Year	1:40pm [™]
edic min		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of	Death	4c. County of Death	
	•	Devlin Manor Nursing	Home	Cumberland		Allegany	
ral	0	Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Bir Min. (Month, Da	th Year) 9. Birth	place (State or Foreign
tor		207-24-4335	79 Yrs.	Montale Days Hours	Mar 3	0, 1930	place (State or Foreign htry) MD
		Usual Residence of Decedent	10a City Tayya av l				0d. Inside City Limits
1	_	MD 10b. County Allegany	10c. City, Town or L	rriganville			1 □ Yes 2 ☑ No
	ctc						^
	Ē	10e. Street and Number		10f. Zip Code		10g. Citizen of What Coul	ntry?
	Funeral Director	10906 Poorbaugh Ave		2152		USA	
	nue.	Armed	ecedent Ever in U.S. 13. Forces? S 2 No	. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	in? (Specify Ye's or No Puerto Rican, etc.)	 14. Race - Americ Black, White, 	
	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 3 ☐ Widowed 4 ☐ Divorced Year o	Give Korea	1 ☐ Yes 2 ☐ No Specify:		Specify: W	hite
	ed	15. Decedent's Education		edent's Usual Occupation		16b. Kind of Business/In	
	plet	(Specify only highest grade complete	d) (Give	e kind of work done during most DO NOT use retired)	of working		
	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	orer		PPG	
	Be C	17. Father's Name (First, Middle, Last)			's Name (First, Middle	_	
	To	Harvey Geiger, Sr.		CI	ara Dietle	Geiger	
		19a. Informant's Name/Relationship (Type. Print)		ing Address (Street and Number	r or Rural Route Numb	er, City or Town, State, Zin	MD 21524
		Vida Geiger		0906 Poorbaugh			
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	20b. Place of Disp cemetery, cre	ematory or other place)	Date 12/1/2000	20c. Location - City or To	
		4 □ Donation 5 □ Other (Specify)	Trocky Ga	p Veterans Cemete		Flintstone	MD
опсе		21. Signature of Funeral Service Licensee	,	22. Name and Address of Facility			
9 01						and, MD 21502	
		23a. Part 1. Enter the disease, or complications that shock or heart failure. List only one cause o	t caused the death. Do not er each line.	iter the mode of dying, such as o		rrest,	Approximate Interval Between Onset and Death
an		Immediate Cause (Fihal disease of condition)	dero care	roma of	The he	eng/	was
al er		resulting in death)	to (or as a consequence of):)		8
	_	Sequentially list conditions, if any, leading to immediate Due	- (U	
	Examiner	cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):				
	xar	that initiated events c	to (or as a consequence of):				
	ig g						
	cian/Medical						
	N		outcome of pregnancy			23d. Date of deliv	ery
	icia	1 Vec 2 No 4 Pr	ve birth 2 Tetal death 3 egnant at time of death 5			Month	Day Year
	Physi	9 ☐ Unknown 9 ☐ Ur	known		1		
	Ϋ́	Part V. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribute to t	he cause of death?
	Completed by	plymentia			1 🗆	Yes 2 No 3 Pro	bably 4 ☐ Unknown
	bet				24a. Was	an 24b. Were auto	opsy findings available ompletion of cause of
,	E					rmed? death?	
	Bec	25. Was case referred to medical examiner?		26. Place	of Death (Check only of		
		— Hospital	☐ Inpatient 2 ☐ ER/Outpatie	ent 3 □ DOA Other:	sing Home 5 🗆 Resi	dence 6 ☐ Other (Speci	fy)
	ü		te of Injury onth, Day, Year) 28b. Time of Injury	Work?	28d. Describe	now injury occurred	
	cati	2 Accident investigation		M 1 □Yes 2 □ N	lo		
	Certification: To	determined 200. Pla	ce of Injury - At home, farm, si ilding, etc. <i>(Specify)</i>	treet, factory, office	28f. Location (City or To	Street and Number or Run vn, State)	al Route Number,
		One Carbifford	the best of any browledge dea	ath a command of the stime of the			
`	Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, dea e basis of examination and/or i anner stated.	ath occurred at the time, date and investigation, in my opinion, deat	u place, and due to the th occurred at the time,	date and place, and due t	o the cause(s)
	Mec	29b. Signature and title of certifier	t taleu.	29c. License number		29d. Date signed (Month,	Day, Year)
		1 hours	5 Sun	DSHHI	1	11-79-	09
	ŀ	30. Name and address of person who completed co	ause of death (Item 23a) (Type	Print)		11 21	
Q		BENERI V (ALKIN	18.MD	00 MEMORIAL	AVE CO	MRERIAND	MD 21502
Sta	te	31. Date filed (Month, Day, Year) 32	. Registrar's Signature	An an an an an an an an an an an an an an		TUDE JUNIO	1110 010
istr		DEC 0 7 2009 Lever	A CONTRACTOR OF				

Registrar

	amend #!	State of Marylan						0 20067	
	Registrar 1. Decedent's Name (First, Middle, La	st)	Cei	tificate of I	Death	2. Date of De	Reg. No. 200	3. Time of Death	
Physician /Medical	ELEANOR V.	GROSSNICK	KLE			NOVEM!	er Day 29 Ye	09 1:53 AM	
Examiner	4a. Facility Name (If not institution, give street and number)						4c. County of D Washin		
	Fahrney Keedy Me		last hirthday)	Boonsb If Under 1 Year	Oro If Under 24 Hrs	. 8. Date of Bir	h 9.	Birthplace (State or Foreign	
Funeral Director		□M 2\\ F\ 89	Yrs.	Months Days	Hours Min.		y, Year) 3,1920 Ma	Country) aryland	
and	Usual Residence of Decedent 10a. State 10b. County	10c, Cit	y, Town or Lo	cation				10d. Inside City Limits	
Maryla Frod a	Maryland Washin		oro			1 □ Yes 2√2 No			
or 28a	10e. Street and Number			10f. Zip Code 10g.			10g. Citizen of What	g. Citizen of What Country?	
ath wi	8507 Mapleville R				21713			USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Martical Exeminer must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	1 □ Yes 2 ☑ No		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 ☑ No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
21215-0030 21215-0030 ed within 72 hours a ygiene. er than "natural", of, the Mudical Error Completed by	3 X Widowed 4 ☐ Divorced	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)			, ,	Sb. Kind of Business/Industry			
215 hin 72 an "na medic	17. Father's Name (First, Middle, Last) Oscar Albert Brandenburg								
ed wit ed wit ygien ner tha it, the					Own Home				
Maryland 21215-0036 d 2 should be filed within 72 hours aff tith and Mental Hygiene. Z is marked other than "natural"; or traumatic event, I'm Mudical Event To Be Completed by F					,	*			
laryla 2 should I and Men is marke aumatic				ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
re, M 1 and 2 Health tem 27 i	Ellen Catlett/daughter 16746 Spielman Road, Fairplay, Maryland 21733								
altimore, mit. Pages 1 ar rmit. Pages 1 ar partment of Hea portant: If iten y Injury or other	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation S Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Crossnickle Brethren Dec. 3, 2009 Myersville, Maryland								
Baltime	21. Signature in Funeral Serice Lice			. Name and Addres	-		4 Main St		
	222 Part 1 Street the discost or com	aligations that aquied the death		icketts !			ersville,		
Physician	shock, or heart failure. List only Immediate Cause (Final disease or condition	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death							
/Medical Examiner	resulting in death)	Due to (or as a consequence of): b. Care mansular Accidant							
je je je je je je je je je je je je je j	Sequentially list conditions, if any, reading to interediate cause. Enter Underlying Cause (Disease or injury	Hecidun				37			
executed in and ial-transit	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
18760, Care be executed physician and the burial-transit dical Examir		d	derice off.						
	IF FEMALE:								
death certifice e attending produce as iclan/Mec	23b. Was decedent pregnant in the past 12 months?					23d. Date of Month	delivery Day Year		
the de ached	1 ☐ Yes 2 125No 9 ☐ Unknown	9 🗆 Unknown	eatn 5L	Other (specify) _					
I Records, P.O. Box 6 The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be d								Probably 4 Dunknown	
al Record The law requir cate has been s page 2 should				a		24a. Was autop perfo	prior to completion of cause of death?		
of Vital Re hysician: The la his certificate ha I director, page 2	25. Was case referred to medical 26.				26. Place of De	1 ☐ Yes ath (Check only o	2 No 1 1	/es 2□No	
Of Vita Physician: this certifice ral director, granting To Be C	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
Jn C ding P After 1 funera	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how					now injury occurred	injury occurred	
DIVISION Of tall or Attending Phys is after death. all Director: After this ied in by the funeral dir. Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hamiside determined	eet, factory, office 28f. Location (Stree			Street and Number or	r Rural Route Number,			
DIN ital or rs afte al Dir led in I	4 ☐ Homicide determined	building, etc. (Specif	City or Town				n, State)		
o the Hospi ithin 24 hour o the Funer ompletely fill									
	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)		
To the within To the comple	29b. Signature and title of certifier			29c. License	e number				
DIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To	29b. Signature and title of certifier	2		29c. Licenso	o number	3	11 30		
To the within 2 to the comple	29b. Signature and title of certifier 30. Name and address of person who Muhammad Khalid			Print)	15232	3		Zoeg	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 12:20 P M November 11, 2009 Ferris Ivan Graff /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Year Hours Months 1 € M 2 🗆 F 02/18/1925 Yrs Michigan Director 84 579-20-8362 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, trailleaders. 1 ☐ Yes 2 1 No Director Germantown MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 17910 Red Rocks Drive 20874 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. <u>م</u> 1946 Specify: White 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I be filed within 7 intal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Drywal1 Owner 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Adele Ferris Alfred Graff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17910 Red Rocks Drive Germantown, Maryland 20874 Cheryl Patterson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ■ Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery: 2009 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia e Cause (Final **Physician** disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner History of Dysphagia Sequentially list conditions, if any, leading to immediate cause. Classes or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Dementia and resulting in death) Last Due to (or as a consequence of) attending physician a Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 12, 2009 D0054566

State Registrar

DHMH 17 Rev 1/2001

9801 Georgia Avenue #1-17 Silver Spring, MD. 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunitha Bhogavilli M.D.

NOV 16 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State
Registrar AMFND#23a-TTperMF, 11-16-09, FMW, McC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Russom Tefery Ghebrevohanes November 8, 2009 12:45 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lorien Nursing Home Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Eritrea Months Days Hours Min. Feb. 1, 215-61-8462 1934 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏿 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 12526 Veirs Mill Road, Apt. 201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ₺ No Black, White, etc. ģ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Religion Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ghebreyohanes Tefery Amarch Zeru injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 20853 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Saba Yohannes/Daughter 12526 Veirs Mill Road, Apt. 201, Rockville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other pla Evangelical Lutheran of Eritrea Cemetery t Burial 2 🗌 Cremation 3 🖺 Removal from State Church 4 ☐ Donation 5 ☐ Other (Specify) Asmara, Eritrea 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spr MD 20901 23a. Part 1. Exter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip Approximate Immediate Cause (Final Enysician Medical resulting in death) Due to (or as a consequence,of) Examiner ev Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury Exami b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ERTIFICATION Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown s been signed by the should be detached Part II. **Other significant conditions** contributing to death but not re**s**ulting in the **unde**rlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2[™] No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 🗶 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier прleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) ٩ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OW 5 Registrar's Signat State Registrar

P.O. Box 68760, Division of Vital Records,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

ANURAdha

State Registrar

31. Date filed (Month, Day, Year)

NOV 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (030) (160RG) AVE, SILV (R. SPR

2. Registrar's Signature

		Please Type or Print in State of Maryla	nd / Depa		Health and M	lental Hygi	ene	20071	
Physicia	an	1. Decedent's Name (First, Middle, Last) Robert Louis Gosselin		illicate of	Death	2. Date of Death November	. №2009 - ™, 2009	38971 3. Time of Death 10:10 p M	
/Medic Examin	al	4a. Facility Name (If not institution, give street and number) Carroll Hospice Dove House		, ,	r Location of Death	November	4c. County of Death Carroll		
uneral rector		5. Social Security Number 6. Sex 1. 1 M 2 □ F 82	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 27,	year) 9. Bir Co 1926 Wash	thplace (State or Foreign untry)	
-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. C Maryland Carroll	City, Town or Lo		anchester			10d. Inside City Limits 1 □Yes 2x No	
23a or 28a ist be noti	al Director	10e. Street and Number 2108 Ebbvale Road		10f. Zip Code	21102	100	g. Citizen of What Co USA	l untry?	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWI		Was Decedent of H If Yes, specify Cub 1 □Yes 2 No	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: N		
r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire cseman/Tr	during most of worki d)	ing 16	6b. Kind of Business, Hors		
arked otheratic	To Be C	17. Father's Name (First, Middle, Last) Joseph J. Gosselin	aiden Surname)						
n 27 is m ier traum		19a. Informant's Name/Relationship (Type. Print) Elizabeth M. Gosselin, wife			and Number or Rura Road, Man		City or Town, State, . MD 21102	Zip Code)	
ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SOUTHY, crer	sition (Name of matory or other place L Cremato	ce)	1/2009	oc. Location - City or Winfield		
Importa any inj		21. Signature of Funeral Service Licensee					oraw Funer er, MD 211		
sician		23a. Part 1 Enter the disease, or complications that caused the dealershoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ath. Do not ent	er the mode of dyi	ng, such as cardiac (or respiratory arres	st,	Approximate Interval Between Onset and Death	
edical miner	_	resulting in death) Due to (or as a conse Sequentially list conditions, if any, leading to immediate Due to (or as a conse	,						
cian and vurial-transit	ıl Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause). Enter Underlying Cause (Disease or injury that initiated events cause). Due to (or as a consequence of):							
ling physid e as the b	Medical	d					T		
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery Month Day Year	
en signed t	þ	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.			o the cause of death?	
cate has be , page 2 sh	Completed					24a. Was an autopsy performe 1 □Yes 2	prior to	utopsy findings available completion of cause of	
s certifi director	ice 6 🔀 Other (Spe	Hospice							
r: After thi	ation: To	1 Yes 2 No 1 Inpatient 2 [27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Inju		28d. Describe how		cary) ~	
al Directo led in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
the Funer	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my ki 2 ☐ Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
DVA.	Σ	29b. Signature and title of certifier	1	29c. Licens	6459	7 29	d. Date signed (Mon	th, Day, Year)	
.1 0 .,		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,	Print)	125AMIN	Ster Hi	21157		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sign NOV 1 2 2009	nature	pare		-10 / 01			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19 2009 A^{M} Mary Jane Goodhand Nov. 4:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL GARDENS EASTON TALBOT 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ XF Months Days Hours Min. Director 190-16-9207 87 11/12/1922 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 X Yes 2 □ No Director traumatic event, the Medical Examiner must be notified MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 516 WILLIAM HILL GARDENS 21601 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify þ 3 XWidowed 4 ☐ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK WILLARD MCCAL NELLIE COWAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr WILLIAM S. GOODHAND, III/SON 1011 MAGOTHY AVE, ARNOLD, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 11/23/09 SUDLERSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 W. CYPRESS ST. MILLINGTON, MD 21651 21. Signature uneral Service Li Jan 020 Approximate Interval Between Oriset and Death 23a. Part 1. Enter the shock, or hear e disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tailure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequency Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year the detached 9 Unknown 9 Unknown à signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate 2 No 2 🖪 No 1 Tes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1□ Yes 2 🗷 No 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Box 68760, P.O. Records, **Division of Vital**

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician: : After this certific funeral director, he Funeral Director: Af

the 2

> State Registrar

Medical

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Easton, MD 21601 28474 Kings wood 8 William

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) Regiotrar's Signature 32. NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Catherine Gelzhiser 2009 November 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Apr 19, Ye Pennsylvania Director 160-12-7284 90 Usual Residence of Decedent Show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 12 Turk Garth USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene, item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications 12 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ida May Hummel Daniel Rhodes Winter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heatth a Important: If item 27 is any injury or other tra Turk Garth Catonsville, MD 21228 Howard L. Gelzhiser/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 11/16/09 Woodbine, MD 4 Donation 5 Other (Specify) 21. Sign of Funeral Service Ligens Ging Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HODGKIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) law requires that the death certificate be executed use as the burial-tran signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown a Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I autopsy performeda Yes 2 No Hospital or Attending Physician: The **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? TOSPICE Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner/To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one ٥ 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Gelzhise

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	laryland				Mental Hy	giene		
			1 - State Registrar			Ce	rtificate of	Death	F	Reg. No. 2	119	38971
Н	Physici	an	1. Decedent's Name (First, Middle, Las						Date of Dea Month	ith Day	Year	3. Time of Death
	/Media		William Edward G						Nov.		2009	6:25 P M
	Examin	er	4a. Facility Name (If not institution, give					r Location of Dea	th	4c. County	of Death	
pe!			Northampton Mano 5. Social Security Number 6. Se		& Re		Fr If Under 1 Year	ederick	8. Date of Birt		ederi	ck lace (State or Foreign
	Funeral Director		214-28-3832	ÄM 2□F	7		Months Days	Hours Min		y, Year)	Coun	aryland
	ס		Usual Residence of Decedent						100. 2	0, 1751		aryrand
	urylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Ba-f s	Director	Maryland Freder	ick	Fr	rederi						1X Yes 2 No
	vith th	Dir	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	s 23g	eral	317 E. Second St	12. Was Decedent	. Francis III 6	140	217		2	USA		and the state of
10	lter de	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	5.	If Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- to Rican, etc.)	Blac	e - Americ k, White, e	etc.
036	Jrs af	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🛣 No	Specify:		Specify	:	White
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, the "natural" or Items or the treithed at	Completed by Funeral	15. Decedent's Ed (Specify only highest grad	ucation		16a. Dece	dent's Usual Occup	pation	arking	16b. Kind of Bu	ısiness/Ind	dustry
7	ithin De.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire	d)	iking			
2	dygien her th	CO	12			Truck	Driver		(=)	Food 1		try
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Ž	hould od Me mark matic	၀	19a. Informant's Name/Relationship (7			10h Mailie	na Address (Street		M. Fugit		State Zin	Coda
Maryland	id 2 s Ith ar 27 is 1rau		Nancy Mayhew/Dau						jamsville		21754	•
ē,	f Healifem		20a. Method of Disposition	•	20b. Pl		sition (Name of natory or other place		Date 27-2009	20c. Location -		
Baltimore,	Pages ento nt: If		1 X Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		;		natory or other pla tingham (;	27-2009	Colora	Мат	evland
alti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Even. The Country or other traumatic event, the Medical Even. The Country or other traumatic event, the Medical Even. The Country or other traumatic event, the Medical Even. The Country or other traumatic event, the Medical Even. The Country of th		21. Signatur of Funeral Service Licens		.3.		2. Name and Addre	ess of Facility				yrana
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ш			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	ncations that cause one cause on each I	d the death.	. Do not ent						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	SEP	<15							Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ence of):						
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	ence of):						
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P.O. Box	eath certific attending p for use as	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	27			e of delive	,
П	ed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			Other (specify)	-y		Mo	nth	Day Year
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a	n: Th ficate r, pag		OF Management to modical						1 □Yes	2 No	Yes	2 □No
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o	ding Physician: The lav h. After this certificate has funeral director, page 2 s	Ĕ	27. Manner of Death	28a. Date of Inj	ury	28b. Time o	28c. Inju	ry at	Home 5 ☐ Resid			<u>y) </u>
<u>o</u>	ath.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Di	ay, Year)	Injury	M 1□	k? Yes 2 □No				
Division of Vital Records,	ar degree by the	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At hor tc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
	ital or rs afte al Die	Certification: To		7/					4			
	Hospi 4 hou Tuner ely fill		(Check only 2 Medical Exam	sician: To the besi	t of my know of examinati	vledge, deat ion and/or in	n occurred at the ti	ime, date and place	ce, and due to the	cause(s) and ma	anner as s	tated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	29b. Signature and title of certifier	and manner s	tated.							
	2 ≥ 2 ≤ ⊃		290. Signature and title of certifier	2 A N			29c. Licens			29d. Date signe		
	_		20. Name and address of names with	MD omploted source of	death /lt	020\ (%	Delint)	7041/	Freder		0-6	7.
-	8		30. Name and address of person who of	Completed cause of	the ain (item	ZJa) (Type,	Talana a	1 X1 a	Fresho.	11/6	MN	7.1717
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Registrar

NOV 2 4 2009 Server B. Janks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 [] [] 9 AMEND#6&29D11/23/09pqcbci 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. 16, 2009 **Physician** William J. Goodman 1:55a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5256 Ferry Branch Lane Lothian Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days Hours Min **1**X M 2 □ F 79 Director 576-32-1364 22,1930 Poyen, Ark. Usual Residence of Decedent death with the Maryland d 2 should be filed within 72 hours after death with the Marylan th and Mental Hyglene.

?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the New Item Exercitival be positived at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 9206 Crandall Road 12. Was Decedent Ever in U.S. Armed Forces?

TX Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 1947-3 Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 1950 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Maryland State Senator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be fill partment of Health and Mental H portant: If item 27 is marked ott y Injury or other traumatic even Be Willie Goodman Artie Fitzhugh Sumner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Goodman (Wife) 9206 Crandall Rd. Lanham, MD. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory Nov.21,2009 Beltsville, Maryland 4 Donation □Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home Funeral Service Licensee . Signature 6 ouc. 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) **Physician** Dementia unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 □Yes 2 ΪNo 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\to\) Nursing Home 5 \(\frac{1}{12}\) Residence 6 \(\frac{1}{12}\)Other (Specify) Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this SON funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After RESIDENT 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062534 Nevenber 16. Shewan, MD November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rita Dhawan, MD 9055 Chevrolet Dr. #103 Ellicott City, MD 21042 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 8 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 () () 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Hrthur /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City. Town, or Location of Death Examiner Western Maryland Regional Medical Center 5. Social Security Number If Under 1 Year | If Unde Date of Birth (Month, Day, Year) Jul 12, 1926 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD Days Hours 1₩ M 2□ F 213-22-3689 Director 83 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, It e Modical Examiner must be notified at MD Allegany LaVale Director 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 McKenzie Road 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: þ 3X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) machinist Celanese Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blaine Hoyle Fammie E. (Squires) Hoyle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1797 Valley Side Drive Frederick MD 21702 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Lynne Phillips daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State to Department of Important; If it any Injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/2/2009 LaVale MD 4 ☐ Donation 5 ☐ Øther (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, parts, or he in trailure. List only one cause or each line. Immediate Cause (Final disease or committee or committee)

a. Due to (or as a conseigneed): Onset and Death **Physician** ue to (or as a conse y ence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached it 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ 10 24a. Was an autopsy 1 □ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death.

Il Director; A

ed in by the fu 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

KINS, M.D. 500 MEMORIAL AVE. CUMBERLAND, MD 21502

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11, 2009 Mathias Hoerauf November 11:43 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5613 Newington Road Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 X F 217-48-1748 05/15/1954 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Montgomery Bethesda 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5613 Newington 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Reading Therapist Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Justin Mathias Laura Curry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall T. Hoerauf / Spouse 5613 Newington Road Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet. 11/16/2009 Silver Spring, MD 21. Signature of Funeral Service 22. Name and Address of Facility Joseph Gawler's Sons Inc. Will 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications mal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE

Physician /Medical Examiner The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

s 23a or 28a-f show ust be restified at

er than "natural", or items

of Health and Mental Hygie fitem 27 is marked other t r other traumatic event,

Department of H Important: If ite any Injury or ot once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

Completed by

Be

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Examine attending physician for use as the burial Completed by Physician/Medical signed by the a been Be Certification: To ospital or Attending Phours after death.
neral Director: After it yfilled in by the funera After

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year							
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
		1 ☐ Yes 2 【本No 3 ☐ Probably 4 ☐ Unknown							
		24a. Was an autopsy performed? 1 □ Yes 2 ▼ No							
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5x Residence 6 □Other (Specify)							
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) Injury Work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 12 Certifying P	ysician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.							

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0035045

29d. Date signed (Month, Day, Year)

November 12, 2009

State Registrar

Medical

(Check only one)

title of certifie

29b. Signature a

Philip G. Henjum MD 18109 Prince Philip Dr. #200 Olney, MD 20832 31. Date filed (Month, Day, Year) NOV 16 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

e Hospital of 24 hours are Funeral D

To the within 2

30

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			1 - State Registrar		Ce	ertificate of	Death		Reg. No. 200	2 002.0
-4-	Physici /Medic			ed Howe	Hauschil			2. Date of Dea Month Novemb	er 13, 200	19 4:40 pm
	Examir Funeral	ner	4a. Facility Name (If not institution, give Rockville Nursi 5. Social Security Number 6. Se	ng Home	e (In yrs. last birthda	Roo	r Location of Death CRUILLE If Under 24 Hrs. Hours Min.	8. Date of Birt		eath ontgomery Birthplace (State or Foreign Country)
ŀ	Director		577-16-8236 Usual Residence of Decedent 10a, State 10b, County	IW ZWI	89 Yrs.			10/15/	1920 Wa	ishington, DC
	he Maryla 18a-f shov otified at	Director	Maryland Montgome	ry	Toc. City, Town of I	Sil	lver Spri			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	and the name of th	I Dir	10e. Street and Number 2701 Dawson Ave	NIIO		10f. Zip Code	20902		10g. Citizen of What	Country?
ထွ	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2☐ Married	12. Was Decedent I Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Ye} \) If Yes, Give	Ever in U.S. 13	I. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No		pecify Yes or No- Rican, etc.)		merican Indian,
2-0036		eted by	3 📆 Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grad	Year or Dates:	16a. Dec	edent's Usual Occup re kind of work done	ation	king I	16b. Kind of Busine	White ss/Industry
2121	filed within Hygiene. ther than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	Volunte			Charitabl	Le Organizatio
	be filec ntal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Maryland	should ind Mer marke	으	Wyman 19a. Informant's Name/Relationship (7)	rpe. Print)	, 19b. Mai	iling Address (Street			Blondell I er, City or Town, Stat	
	s 1 and 2 f Health a ftem 27 is other trai		William J. Armstro	ng,III- S			ıy St., S		oring, MD	
TOTE F	e = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, ci	position (Name of ematory or other place 1 Mem. Par	i	Date	20c. Location - City	
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Sign pare o Funeral Service Licens		0709	22. Name and Addre	ss of Facility Hi	nes-Rina	Rockville aldi Funer Silver Sn	al Home, Inc. ring, MD 2090
	1		23a. Part I. Enter the disease, or comp shock, or heart failure. List only of	ications that caused ne cause on each lir						Approximate Interval Between Onset and Death
5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		atic Live a consequence of):	r Disease				Onset and Death
	Examiner		Sequentially list conditions,	Atrial	Fibrilla	tion				
,	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. <u>Chroni</u>	a consequence of). C Kidney 1	Disease				
68/60,	cate be ex ohysician the burial	7	Hungatonsive Heart Disease							
O. Box 6	the death certificate the attending physiched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy	1		23d. Date of Month	delivery Day Year
ecords, P.	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.			e to the cause of death? Probably 4 🔀 Unknown
r	The ate h	Completed						24a. Was autop perfo	rmed? prior	
VIta	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	-1 00500	ont 3 DOA Oth	26. Place of Dea			
n or	ng Tel	on: To	1 ☐ Yes 2 页 No 27. Manner of Death 1 页 Natural 5 ☐ Pending	28a. Date of Inju	nt 2 ER/Outpati ry 28b. Time Year) Injury	of 28c. Injur	4 L Nursing H		dence 6 Other (5 now injury occurred	pecify)
DIVISION	r Atten ter deat irector: I by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubulding, etc.	iry - At home, farm, s c. (Specify)		Yes 2 □ No	28f. Location (S City or Tox	Street and Number of vn, State)	Rural Route Number,
_	To the Hospital of within 24 hours aft To the Funeral D completely filled in	edical C	29a. Certifier 1 🔀 CertifyIng Phy (Check only one) 2 Medical Exam	sician: To the best of ner: On the basis of and manner sta	examination and/or	ath occurred at the tir investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
-	within To the complex	Me	29b. Signature and title of certifier		บา	29c. Licens			29d. Date signed (M	
	1-		30. Name and address of person who c		eath (Item 23a) (Type		147330		November	14, 2009

State Registrar

Thomas V. Joseph, M.D., 50 W. Edmonston Dr., Suite 207, Rockville, MD 20852

31. Date filed (Month, Day, Year)

NOV 16 2009

Registrar's Signature

A gardinary DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38979 Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DUCK SIIN HAN 3:25 A 2009 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Ye July 18. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M 2 🕱 F Hours Director 96 218-78-8457 Korea Usual Residence of Deceden Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6709 Newbold Drive 20817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ 1 ☐ Yes 2 X No Specify: Specify: Asian Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) per it. Page 1 and 2 should .e filed within Der artment of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatir event, the 1 on. e. 6 Laundry Worker Healthcare Services Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Sung Yoon Kim Hyo Sun Kim 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Janet H. Vissering 6709 Newbold Drive, Bethesda, Maryland 20817 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 16. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Norbeck Memorial Pk 4 Donation 5 Other (Specify) 2009 Olney, Maryland 21. Signature of Funeral Service Licensee 10# 1070 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Sepsis Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury Cerebrovascular Disease Years burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical pe Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Diabetes Mellitus, Acute Renal Failure, 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been ; page 2 should Chronic Kidney Disease Stage 2, Hypertension Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' the Hospital or Attending Physician: The certificate Advanced Mixed Dementia Yes 2 X No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ပ 1 🗌 Yes 1 X Inpatient 2 - ER/Outpatient 3 - DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

31. Date filed (Month, Day, Year) NOV 16 2009

29b. Signatura and title of certifie

only one)

Shyamsundar Rajan, MD, 9801 Georgia Avenue, Suite #1-17, Silver Spring, MD 20902 Registrar's Signatur sur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-53367

29d. Date signed (Month, Day, Year)

November 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per doc 8898 12-29-09 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State AMFND#10 coerFH, 10-24-09, BW, Mco Registra AMFND#10-perFH, 11/24/09, BW, Mco 1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death 3. Time of Death Month Day 10 **Physician** Hicks 5:06 hristine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IA Koma ASHINGTON ADVENTIST HOSPITAL If Under 24 Hrs 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number **Funeral** Year) Min 1 ☐ M 2 🗷 F Months Days Hours 578, 24. 1642 Director glan. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show of other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be rediffed at 1 Pres 2 No **Funeral Director** DC ASHINGton death with the 10g. Citizen of What Country? 10e. Street and Number 20002 15A FRANKliN. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>م</u> 3X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other than 'any Injury or other treumatic event, tre Magnes, any Injury or other treumatic event, tre Magnes. Elementary/Secondary (0-12) College (1-4or 5+) tician Kommunity HovosoTE TRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ ONSUELLA WILSON, 1.44 lor 19b. Mailing Address (Street and Number or Rural Route Mumber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20002 Ampbe Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility 21. Signature of Funeral Service Kinnsee MURRAY FUNERAL HOME NW. Wash. OC 20011
48046 ECRETICA AVENUE NW. Wash. OC 20011 1400943 Leliuning 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final athro sderotic **Physician** 1 Per disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to find eligible cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse mence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certification: To 27. Manner of Death

1 Natural
2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00069081 Bran Tenney 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Century Bluck Suite 200 (remain town MV 20814 20010 (PMn Brian Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 19 Registrar

09-08918 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Danny Hooper 2009 38982 1- For State Certificate of Death Reg. No Registra 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day November 16, 2009 2049 hrs **Medical Examiner** COPER 4a. Facility Name (i Aot institution, give street and number) 1c. County of Death 4b. City, Town, or Location of Death Laurel Regional Hospital Laurel Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral 5. Social Security Number 96-4418 44-4481 Days Hours Min Director 1 M 2 03-10-Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State 1 Ves 2 No 28a-f shov notified at once. death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Numbe U.S.A 20743 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Married Yes BIACK . Pages 1 and 2 should be filed within 72 hours after iment of Health and Montal Hygiene. Tant: I fiten 27 is marked other than "uatural", or or other traumaite event, the Medical Examiner. f Yes, Give Year Yes 2 No specify: Widowed Divorced ş 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 UN Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNAR. (GOMAZ) HOOPEN Hooper George 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave, Hegt, Md ATRICIA ROLLINS CAPITAL Wheelen-Mother 20c. Location 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 11-30-09 Important: injury or oth -(NCOIN Cometuy Department Donation 5 Other Specify & WILLIAMS Signature of Funeral Service Licenses 22. Name and Address of Facility the House William) and TN.W Washington Di Zoon 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic (heroin) intoxication Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - fransit The law requires that the death certificate be executed Physician/Medical X AMENDED 23a,27,28a-f, per ME g898 12/17/09 TT X UNPENDED ned by the attending physician detached for use as the burial Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? ✓ Yes 2 No Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifi 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes ٩ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Yes XX No 1 Natura hin 24 hours after death. the Funeral Director: aeral Director; Pending 11/16/09 unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Jessup Correctional 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State)
BOX 53 determined (Specify) PO 534 Jessup, MD Institutional Homicide

Registra

29a. Certifier 1

Signature and title of certifie

Laron Locke MD. 31. Date filed (Month, Day,

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 17, 2009

and manner stated

Assistant Medical Examiner

ed cause of death (Item 23a)

Registrar's Signat recens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) $r^{\text{Day}}19, 2009$ **Physician** November 5:30P M Verna S. Hayden /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2614 Fort Drive Suitland Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month Day, Oct 11, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 - M 2/1/1 0ct Yrs. Duluth, 476 16 0167 Director Minn Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machal Experiment must be applied at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 📆 🗓 No Director Maryland Prince George's Suitland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 2614 Fort Drive 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 5 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □XXX Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Defense Communications Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oskar Sorfjord Christine Marie Olson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen Pierce (Daughter) 9304 Colesville Road, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Nov 21, 2009 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 014 Alexandira Ferry Road, Clinton, MD 20735 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a conse Pience of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 1∐ Yes 2∭ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner enacted. 29a, Certifier (Check only nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 who completed cause of death (Item 234) (Type, Print) Name and address of person George Wathen, MD 11345 PEMBROOKE SQ. # 103 Waldorf, Md.20603 31. Date filed (Month, Day, Year) 32/ Registrar's Signature State NUV 2 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / I	-			ental Hygie	ene	9	38984
			Registrar 1. Decedent's Name (First, Middle, La.	ofi	Certificate	e of Deat		Reg	g. No. 4 U (7 2	
	Physicia Medic		Elizabeth Moore	,					er 17,	2009	3. Time of Death 9:40 A M
- and a	Examin		4a. Facility Name (if not institution, give 3491 S. Leisure V		- ,,	Town, or Locati			4c. County of Montgor		
	Funeral Director		5. Social Security Number 6. S 239–58–2088	THO VE	hday) If Under Yrs. Months	1 Year If Un Days Hou		Date of Birth (Month, Day, You 20,	(eag) 1941 I	9. Birthpla Country North	ce (State or Foreign Carolina
1	show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location					100	d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Montgome	ery Silver	Spring						1 ☐ Yes 2 🌠 No
14	with the s 23a or ust be n	Funeral D	10e. Street and Number 3491 S. Leisure V	World Blvd.	10f. Zip	906			g. Citizen of Wh SA	at Country	y?
920	s after death ral", or item: Examiner m	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If Yes, spec	ent of Hispanic ify Cuban, Mex 2 X No S <i>p</i> ec	Origin? (Specifican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Black, Specify:	White, etc	5.
21215-0036	I and z should be filed within /z hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	Decedent's Usua (Give kind of wor life. DO NOT use 1PETVISO	k done during n retired)	nost of working		6b. Kind of Busi		stry
ਰ ੋ	be filed w lental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Theodore Moore			18. M	lother's Name (F	First, Middle, Ma			
Maryland	and 2 should be fill Health and Mental em 27 is marked (ther traumatic ev		19a. Informant's Name/Relationship (1) Leslie A. Wild/Do	ype, Print) 19b omestic Partner 34	. Mailing Address						
<u> </u>	Fage 1 and nent of Hee ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🏅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State cemeter	f Disposition (Nan ry, crematory or o Journey	ther place)	Dat		oc. Location - C	-	n, State
Baltii	permit. Page 1 Department of Important: If it any injury or o		21. Signal of Funeral Service Licen				<u> </u>				784 MD 21029
П			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused the death. Do r						4	Approximate
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Colorectal Cand						3	Ponset and Death Years
- 1	Examiner	ı.	Sequentially list conditions,	b							
pot	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	Due to (or as a consequence of	of):						
90	physician and the burial-transit	dical Ex	that initiated events resulting in death) Last	Due to (or as a consequence of d.	of):						
876	ng phys	Med	IF FEMALE:						1		
P.O. Box 687	of Authoring Priystons. The law requires that the beam certificate be executed birector. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 ☐ Ectopic 5 ☐ Other (sp				23d. Date Monti		/ ay Year
ls, P.O	been signed by the should be detached	ed by PI	Part II. Other significant conditions of	ontributing to death but not resulting i	in the underlying	zause given in F	Part I.				cause of death?
Division of Vital Records,	cate has bee page 2 shot	Completed						24a. Was an autopsy performe	prie	re autops or to comp ath? Yes 2	y findings available bletion of cause of
ita	certificate lirector, page	Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital:			Death (Check or	nly one)			
of V	After this o	ate: To	27. Manner of Death 1 Matural 5 □ Pending	(Month, Day, Year) i	Fime of 2	8c. Injury at work?	280	e 5 A Residend d. Describe how		(Specify)	
ivisior	after death. Director: After this d in by the funeral c	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be determined	De 29a Place of Injury At home for	rm, street, factory	1 Yes 2		f. Location (Stree City or Town, S		or Rural R	oute Number,
	within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 Medical Exam	sician: To the best of my knowledge, iner: On the basis of examination and/o se Practioner: To the best of my know	or investigation, in	ny opinion, deat	th occurred at the	e time, date and	place, and due to	the cause	
- ²	within To the compl	2	29b Signature and title of certifier	Section of the pest of my know		. License numb			d. Date signed (/		
			30. Name and address of person who	completed cause of death (Item 22a)	Type Print)	543	78		11/17/0	<u> </u>	
	l		Cheryl A. Ayleswo	orth, M.D. 2730 Ur		y Blvd.	West S	uite 400) Wheat	on, M	D 20902
	Sta Registra		31. Date filed Month Day, Year 8 2	32. legistrar's Signature	Sparke	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38985 Certificate of Death 11/16/09 Registrar Amended#10c perFH FCHD KS 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ No ember Day 2019 5:27 Ruth Evelyn Hladchuk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick **Examiner** 4c. County of Death Frederick Frederick Memorial Hospital Funeral Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 🗆 M 2 🗓 F Months Days Hours Min. Director Maryland 213-30-8240 78 Mar. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Frederick Maryland Frederick 2500 Waterside Drive 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 2500 Waterside Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) United States Naval College (1-4 or 5+) 4 Personnel Staffing Specialist Laboratory Be 17. Father's Name (First, Middle, Last) should be filed and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ၉ Philip Cleveland Brown Frances Marian Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 ge 1 and 2 sh it of Health a Craig Sheldon Hladchuk, son <u> 2500 Waterside Drive, Frederick, Maryland 21701</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 11/19, 2009 Clinton, Maryland 4 ☐ Donation 5 🛛 Other (Specify) Entombment Signature of Funeral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 23a. Part . Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or he art failure. List only one cause on each line.

Immediate au (Final disease or condition resulting in death)

a. Due to (or as a consequent) 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed bacter emia that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria olitis Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year ed by the a 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Physician; The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? certificate 1 Yes 2 No director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending injury s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 200

State Registrar

Myung 11.31. Date filed (Month, Day, Year

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West. Seventh

's Signature

Chrenn

. Registra

MD

D35106

arks

Street, Frederick, Maryland

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 10, 2009 **Physician** 8:10 A M Ruth Leona Insel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring
Hillnder 24 Hrs. Montgomery 14809 Pennfied Circle Social Security Number 8. Date of Birth (Month, Day, Year) 10/27/1912 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Days Min 1 □ M 2 🛛 F Yrs Director 97 Ohio 279-30-0605 Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 Funeral 14809 Pennfield Circle U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 X No Specify. þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Social Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Jenny Rogen <u>Anton Friedman</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau 10413 Joiners Lane Potomac, MD 20854 Tom Insel / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Grdns, 10/13/2009 Olney, MD 22. Name and Address of FacilityEdward Sagel Funeral Direction 21. Signature of Funeral Service Licensee MO1477 1091 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or a maginations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2 Weeks Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Yrs. Atrial Fibrilation Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and 10 Yrs <u>Hypertension</u> Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ∐Yes 2 X No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after dec To the Funeral Directo completely filled in by the 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D31918 November 11, 2009

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

garas.

Warren Ferris MD. 3305 North Leisure World Boulevard Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 16 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan	nd / Depa <i>Cer</i>	ertment of He Stificate of D	ealth and Me <i>Peath</i>	ntal Hyg	iene 200	9 3898
			1. Decedent's Name (First, Middle, La	ist)				. Date of Deat	h	3. Time of Death
	Physicia /Medic		Ве	ernice Hattie	Johnson		1	Novembe	er 26 2009	1002 A M
the .	Examin		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or L	Location of Death		4c. County of Dea	th
Jane C.			333 Woods Road			Elkton If Under 1 Year	If Under 24 Hrs. 8	D. L (Dist	Cecil	
	Funeral Director		5. Social Security Number 6. S 236-32-1482	Sex 7. Age <i>(In yrs.</i> 1 □ M 2 🕅 F 88	Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, ulv 22.	Year) 9. Bir Co	thplace (State or Foreign ountry)
	pu "		Usual Residence of Decedent 10a. State 10b. County	100 Ci	ty, Town or Lo	nation				10d. Inside City Limits
	faryla F shor	ō	,			Sation				1 ☐ Yes 2 📉 No
	28a-	Directo	Maryland Cecil 10e. Street and Number		E1kton	10f. Zip Code		10	0g. Citizen of What Co	ountry?
	ath with the Marylan \$ 23a or 28a-f show ust be notified at	a D	333 Woods Road			21921			United S	tates
	ems (Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13. \	Vas Decedent of His	spanic Origin? (Speci , Mexican, Puerto Ri	ify Yes or No-	14. Race - Ame Black, Whit	
36	or it	by Fu	1 Never Married 2 Married	1 ☐Yes 2 🛣 No If Yes, Give		□Yes 2X No	Specify:	,	0	
215-0036	hour tural	ed b	3 N Widowed 4 □ Divorced 15. Decedent's E	Year or Dates:	16a Decer	lent's Usual Occupat	tion		16b. Kind of Business	nite /Industry
212	in 72 in "na	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give life. L	kind of work done du DO NOT use retired)	iring most of working			,
7	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Macical Expression of the mother at	Completed	12		Но	memaker			In Her (Own Home
yland	be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Maiden Surname)	
	d Mer marke	P	Jesse Lee Warren	(Turn Deint)	40h Mailin	- Address (Ctood as	Hattie W		City of Taylor Chata	Ti- Cada)
a Z	d 2 sh Ith an 27 is r traur	1 8	19a. Informant's Name/Relationship (Kim Shuler/Grando		Ī	•	Elkton,		r, City or Town, State,	zip Code)
ē,	s 1 an f Hea item 2		20a. Method of Disposition			sition (Name of natory or other place)	Dat	e :	20c. Location - City or	Town, State
Ē	Page:		1 Å Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.	Themoval from State		Cemetery	Decemb 2009	er 1,	Chesane	ake City, MD
galtimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, Its Machal Experiments once.		21. Signa are of Funeral Service Lice				for Funer	-01a D	A	are offy, 11D
ם	9 Q F # 9		- Jones	8. Duka	<u> 1</u>	03 W. Sto	<u>ckton_Stre</u>	et, Ll	kton, MD	21921
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on each line.				respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myocard		ntarctic				
	Examiner			Due to (or as a conseq	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a conseq	quence of):					
j	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events	c						
8/00,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):					
ğ	icate physi s the t	dical		d			<u> </u>			
ROX (n certii nding use a	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
ň	death	Physician/Me	in the past 12 months? 1 □ Yes 2 ■ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		Ectopic pregnancy Other (specify)			Month	Day Year
τ. Ο	at the I by th	hys	9 ☐ Unknown	9 □ Unknown						
ŝ,	res thasigned	þ	Part II. Other significant conditions of Rectal Cancer		sulting in the ur	iderlying cause giver	n in Part I.	23e. Did tob	oacco use contribute to es 2	o the cause of death? robably 4 □ Unknown
cords,	requi	eted	Drabetes							
ě	ne law s has l ge 2 s	Completed	Hypertension					24a. Was ar autops perforn	y prior to	utopsy findings available completion of cause of
VITal	an: The		25. Was case referred to medical				26. Place of Death (1 □ Yes 🦸	No 1 □Yes	s 2□No
_	ysicia is cer direct	o Be	examiner? 1 □ Yes 2 N No	Hospital: 1 Inpatient 2	ER/Outpatien	Othor	,,	4	ence 6 □Other (Spe	ecify)
	ng Ph fter th neral	nc:T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?	· · · · · · · · · · · · · · · · · · ·		ow injury occurred	
DIVISION	tendil eath. or: A the fu	catio	2 Accident investigatio	n		M 1 □ Ye	es 2□No			
<u> </u>	or At after d Direct in by	Certification: To	4 Homicide determined		ome, farm, stre <i>fy)</i>	et, factory, office	28	f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier Certifying P	h ysician: To the best of my kno	owledge, death	occurred at the time	e, date and place, ar	nd due to the ca	ause(s) and manner a	s stated.
	n 24 h	Medical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my op	inion, death occurred	at the time, d	ate and place, and du	e to the cause(s)
	To the Comp	ž	29b. Signature and title of certifier	. 7		29c. License			9d. Date signed (Mon	
			> TKOBEHCHI/ KI	Helian MD		D005	36 75		11/30/09	
	2		30. Name and address of person who Robert A. Mon	teleane MD	111 W.	High St.	Svite 214	, EIK	ton MD	21921
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	9				
	negisti	211	AFC 0 7 2009	Charas B. &	A A ALLES					

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, Steven Robert Johnson 2009 November 3:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/19/1956 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□F 53 Minnesota Director 469-74-3413 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 TXINo Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1008 Bayridge Terrace Funeral 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 [☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Audio Visual College (1-4or 5+) Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Harold Walter Johnson 2 Elizabeth Ann Stokes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Harold Walter Johnson (Father) 1601 N. Innsbruck Drive #226 Fridley, MN. 55432 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November Important: If it any Injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 2009 Frederick, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme Tause (Final Physician disease or condition resulting in death) 4 Days Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Dilated Cardiomyopathy 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 🗆 No certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: 28a. Date of Injury (Month, Day 28c. 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of centier 29c. License number 29d. Date signed (Month, Day, Year) D26540 November 12, 2009 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) --

Carl I. Schoenberger M.D. 16220 Frederick Road, Gaithersburg, MD.

22. Registrar's Signature

Physician /Medical Examiner

Funeral Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

12 should be filed w th and Mental Hygie. permit. Pages 1 and 2 st Department of Health an Important: If item 27 is nany injury or other trau

Physician /Medical Examiner

Physician: The law requires that the death certificate be executed and g physician a attending p for use as t signed by the a page 2 should certificate director funeral c After Hospital or Attending death. To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: filled in by the

Box 68760,

P.O.

Division of Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Novemember 12, 2009 Helen A. Jaffe 5:55₩ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3330 N. Leisure World Blvd. # 619 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 6/19/1920 9. Birthplace (State or Foreign Months Days 1 □ M 2 🗓 F Hours 054-16-5957 89 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Montogmery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 N. Leisure World Blvd. # 619 20906 Funeral United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify White \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dietician / Oceanographer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Apt Bertha Kushlan ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mona Jaffe Rowe / daughter 22 Rich Branch Ct. Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Grdn. 11/16/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licensee. Kurt Blake 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melanoma of foot with brain metastasis, 18 months disease or condition resulting in death) Due to (or as a consequence of): lung and liver metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus type I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Asthma Coronary artery disease 24a. Was an autopsy performed? Sacral pressure ulcer 1 ☐ Yes 2 🗓 No 1 □Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifler (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23958 11/13/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burt Feldman, MD 3305 n. Leisure World Blvd. Silver Spring, MD 20906

State Registrar 31. Date filed (Month, Day, Year)

NOV 16 2009

completely

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ber 16 **Physician** 2009 Mary L. Jefferson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's DOctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 1/10/1950 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 F DC Director 577-68-4434 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Executor must be notified. 1X Yes 2 □ No Director Washington DC None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 222 34th ST NE USA 20019 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Personnel Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellaree Coleman Plinie Hammond Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhonda L. Jefferson/Daughter 222 34th St. NE Washington DC 20019 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 11/21/2009 Brentwood, MD 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee Marshall Moo 977 4217 9th St NW Washington DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dysthytamia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit certificate be executed Due to (or as a consequence of): Molignont Perual Effusion Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 No 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Motortita Breat Carcinoma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 21□No 24a. Was an autopsy Hy po tension performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending PI

t within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

KELSON

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FIGAC

NOV 20 2009

MOD52865

12700 Goodboes Promise Drive, Bowie MD 20720

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			For State	State of M	laryland / [Department of			0000	00001
		-	Registrar 1. Decedent's Name (First, Middle,	l ast)		Certificate of	Death	2. Date of Deat	eg. No. 2009	38991
	Physic		$C i \circ$	00	Holiday	Tark	0.4.1	Month	Day Year	3. Time of Death
1	/Medi Exami		4a. Facility Name (If not institution,	give street and number,			or Location of Death	NouEmBE	4c. County of Death	
			CHESTER RIVE	R HOSPIT	AL CENTE	ER CH	ESTERT	owns	KEO	217
	Funeral Director		5. Social Security Number 6 219-14-3312	. Sex 7. Ag 1 □ M 2 🚉 🕇	ge (In yrs. last bir	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, D9 03/	Year) Col	place (State or Foreign intry)
			Usual Residence of Decedent		8 /			09/03/	1922 MI)
	arylan show	_	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	the Ma	ectc	MD Ken	<i>t</i>	Chest	ertown				1XYes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventin	Funeral Director	10e. Street and Number	C+ 1	101 11	10f. Zip Code	ر نم	1	Og. Citizen of What Cou	intry?
	death	nera	11. Marital Status	12. Was Decedent	Ever in U.S.		-	ecify Yes or No-	14. Race - Amer	ican Indian.
98	after or ite	E.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑		13. Was Decedent of If Yes, specify Cul		Rican, etc.)	Black, White	
21215-0036	hours ural",	d by	3 ■ Widowed 4 □ Divorced	If Yes, Give Year or Dates:					Specify: B/G	rck
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nd	be file stal Hy d othe event,	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, N	laiden Surname)	
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	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition	urier	20b. Place of	Disposition Warne of	oridge	D_{ate}	20c. Location - City or T	NJ 08016
Baltimore,	Pages nent of int; If its iry or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Jones S	r, crematory or other pla	ace)	,	hest row.	(1)
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W	death ie atte	icia	in the past 12 months?	4 Pregnant a	2 Fetal death time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of delive	Day Year
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Š		Completed						1 ☐ Yes	s 2 □ No 3 □ Pro	bably 4 Onknown
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ta	Phystcian: The la this certificate had al director, page 2		25. Was case referred to medical	<u> </u>			20.51	1 ☐ Yes 2	☑1 ☐Yes	2 🗆 No
<u> </u>	≥ .º □	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 🗆 ER/Out	patient 3 DOA Oth	26. Place of Death		nce 6 □Other <i>(Speci</i>	6.1
0	ng Ph fter th	L:uc	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry 28b. Ti			8d. Describe hov))
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation	on		M 1 □	Yes 2□No			
Division of Vital Records,	or Attendatter deatt Director: In by the	Certification:	4 Homicide determined		ry - At home, farn c. (Specify)	n, street, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	Hospital 24 hours Funeral tely filled		29a. Certifier Certifying P	hysician: To the best of	of my knowledge,	death occurred at the ti	me, date and place	and due to the ca	use(s) and manner as	stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examination and	or investigation, in my o	opinion, death occurr	ed at the time, da	te and place, and due to	the cause(s)
	To the within 2 To the complete	Ž	29b. Signature and title of certifier	ALD		29c. Licens			d. Date signed (Month,	Day, Year)
	3		* Kramen				066441	No	ovember (09 2009
	ms		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	/pe, Print)	Vision 1	ACTON	MD	21601
	Stat	te							, , , , ,	4001
	Registra	ar	NOV 12	2009 32. Registra	us B.	park				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ophelia Eaton Jenkins Month Day 22:19 <u> 2009</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day Year) 7 - 28 - 1 9 2 7 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours Min. 241 36 8956 Director 82 Durham, NC Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho adical Examiner must be notified at oc. City, Town or Location Hyattsville 10d. Inside City Limits Director Prince George MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 Funeral 7402 18th Avenue #209 e filed within 72 hours after death wirntal Hygiene.
ed other than "natural", or items 2: event, the Medical Examiner must 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Completed Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0 12) Switchboard Operator Education College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Eaton Mental George Hogan 19a. Informant's Name/Relationship (Type, Print)
Brenda Jenkins / Daughter 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip. Code) 6850 Farragut St Hyattsville MD 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Beechwood Cem. 11/28/09 Durham, NC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Briscoe Tonic Funeral Home 2294 Old Washington Rd Waldorf MD 20601 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final drosepsi's Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month 1 Yes 2 9 Unknown 2 No detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? pe Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Consestive Heart Fashive 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate performed? death? 1 Yes 2 🗆 No 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I 25. Was case referred to medical Be examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

State Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

(Check

3

NOV 2 (Month, Day, Year)

James Lightfoot

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

52326

Carroll Avenue Takoma Park, MD 2091

29d. Date signed (Month, Day, Year)

11/19/69

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 2009 WILLIE LEE JONES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PLATA IVISTA ENTER 7. Age (In yrs. last birthday Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min 1 XM 2 ☐ F Director <u> 249-48-1898</u> 10-11-1930 SOUTH CAROLINA Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be notified at once. MD CHARLES WHITE PLAINS 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4025 CLYDE LANE 20695 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimoré, Maryland 21215-0036 1 ☐Yes 2 TNo Specify Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CATERING PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER JONES ELLA MITCHELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMMY JONES-WATTS/DAUGHTER 4025 CLYDE LANE WHITE PLAINS, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY11-21-2009 CLINTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 45 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and birector when the internal director, page 2 should be detached for use as the burnal-transit and by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 🔲 Pregnant at time of death 5 ☐ Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 1 ☐ Yes 2 No 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be To the Hospital or Atter within 24 hours after des To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Light Standard Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certified Medical and manner stated

CA 1

Registrar
DHMH 17 Rev 1/2001

State

404 E. Charles St. LAPLata Md 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Letchford, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 4a. Facility Name If not institution, give street and number) November 13, 2009 55 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 🗶 F 218-40-5152 66 01/03/1943 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Director 1 Yes 2 X No the Medical Examiner must be notified Delaware Sussex Delmar 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 38308 Brittingham Road 19940 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. sint: If item 27 is marked other than "natural", or items 23 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 🔀 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) secretary clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Rhuben Marvel Clevia Anna (unknown) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Gordy/son 6848 Peggy Dr., Salisbury, MD 21804 Department of Health a Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhill Memory 11/23/09 Hebron, MD 4 Donation 5 Other (Specify) Gardens 22 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and is the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSILUCTIVE CHEONIC 2 No 3 Probably 4 Unknown Completed CARDIAC CONGESTIVE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy FIBELLATION ATCIAL 2 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Inpatient Other: 3 🗆 DOA 2 - ER/Outpatient 4 - Nursing Home ၉ 5 Residence 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide

or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death completely filled in by 24 hours a Hospital within 2 the ٥

State Registrar

Medical

31. Date filed (Month, Day, Year, NOV

29b. Signature and title of cortifie

29a. Certifier (check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

M.O.

DHMH 17 Rev 1/2001

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

KF 5-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 38995 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13 2009 **Physician** Choong Keun 9:20 AM November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Bethesda Montgomery Bethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 25, 1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 216-67-0775 90 Director Korea Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Experiment must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Montgomery Potomac 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11305 Colebrooke Terrace 20854 Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: <u>გ</u> Asian Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Baltimore, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hyung Il Kim Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) In Hyung Chung (Wife) 11305 Colebrooke Terrace Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of important: if any injury or once. Norbeck Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2009 Olney, MD 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Fune al Ser Pa 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, shock, or heart failure. ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Cachexia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Tuberculosis Pulmonary and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical Failure to Thrive IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No P.0. ned by the detached 9 Unknown 9 ☐ Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ∐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To e Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident πpletely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funerail 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35791 amus November 13, 2009 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Dr. Merlyn Vemury M.D. 9801 Georgia Ave. Suite#227 Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 29d per phys. G899 1/20/10 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 38996 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Shorter Kennard 10:55^{P™} 7, 2009 November /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 21 F Months Days Hours 578-32-1139 Director 90 June 26, 1919 Pennsylvania Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits if than "natural", or items 23a or 28a-f show Director 1⊠Yes 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6778 Surreywood Lane 20817 by Funeral United States Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If fleam 27 Is marked other than "natural", or items 23 ury or other traumatic event, the "Morel Expurime traus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Shorter ည Mary Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Kennard/Daughter 6778 Surreywood Lane; Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If Ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/13/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike; Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** End Stage Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-t Due to (or as a consequence of) 世2句 Mon t. Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) □Yes 2₺No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Aortic valve stenosis, hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed has been are 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2 🗆 No 1 ☐ Yes 2 🛣 No 1 ☐ Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) \square Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation To the Hospital or Attendir, within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) . Kouel chou,

Registrar DHMH 17 Rev 1/200

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signal

Jocelyne Kouatchou,

NOV 16

31. Date filed (Month, Day, Year)

16374

201 East University Parkway; Baltimore, MD 21218

November 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Certificate of	of Death	R	Reg. No. 200)9 38 99
Modi	Physici cal Exami	an/	Decedent's Name (First, Middle,Last) FAYE ALEXANDRIA	KIRTON		Date of Dea Month	Day Year er 23, 2009	3. Time of Death 0030 hrs
wear	cai Exaiiii	ner	4a. Facility Name (if not institution, give street and number		4b. City, Town, or Location		er 23, 2009 4c. County of Death	
,			Shady Grove Adventist Hospital	,	Gaithersburg		Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours		rth(MM/DD/YYYY) 9. Bir Foreig	in
	Director		122-42-4519 1 M X F	59 y	rs.	July	29 , 1950 🗠	^{untry)} Guyana
	any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation			10d. Inside City Limits
. 1		_	MD Montgomery		mery Village			1 XYes 2 No
<u></u>	Aaryland 28a-f show I at once.	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Coul	ntry?
5	the Nation 1981 of 1981		19423 Brassie Place, #1	03	20886		U.S.A.	
_	th with ems 2. f be n	Funeral	11. Marital Status 12. Was Deceder 1 Never Married 2 Married Armed Forces		Vas Decedent of Hispanic Ori Yes, specify Cuban, Mexican		o- 14. Race - Ameri White, etc.	ican Indian, Black,
	er dea		1 Yes 3 Widowed 4 XDivorced If Yes, Give Year	No 1	Yes 2 X No specify.		Specify: Bla	ack
	urs aft tural' amine	d by	or Dates: 15. Decedent's Education (Specify only highest grade co	mpleted) 16a. Deced	ent's Usual Occupation (Give	kind of work done	16b. Kind of Business/	
u	72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	most of working life. DO NOT	use retired)		
5,0036	within giene. ner tha	dwo	12	Heal	th Care Aide	r's Name (First, Middle,	Private I	r'amily
215	e filed al Hyg ced oth	Be C	17. Father's Name (First, Middle, Last) Arthur Williams			Pamela Odl		
- 5	C m Med	To E	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Nur		•	e, Zip Code)
2	nd 2 sh alth an m 27 i		George Kirton (Son)		Mojave Drive,			Taura State
Baltimoro	of Her		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from S	tate crematory or		Date	20c. Location - City or	
i.	t. Pag rtment rtant: y or of		4 Donation 5 Other Specify:	•1	Irematory . Name and Address of Facilit	11/30/09	Hanover, I	
ď	permit. Departr Import		Lucido A Museus	11	246 N. Washing			·
	hysician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.					Approximate Interval Between Onset and
	/Medical xaminer	E 19	Immediate Cause (Final disease a Cardiac					Death
			or condition resulting in death) Due to (or as a con Cardiac					
		ig	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
Λ		Examine	(Disease or injury that initiated events resulting in death) Last	sequence or):				
D	cuted and transit		d			<u>.</u>		
_	cate be executed physician and he burial - transit	Medical	X UNPENDED AMENDED PI	line a-b, P	II, 27, permE	g899 1/21	/10 TT	
0228			IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	ome of pregnancy		c pregnancy	23d. Date of deliver	y Day Year
89 200	eath certiff attending for use as	rsician	past 12 months?	t time of death	Other (Specify)			
	t the dear by the a	Phy	Part II. Other significant conditions contributing to dea	th but not resulting in the	e underlying cause given in P	art i 23e. Did	tobacco use contribute to	the cause of death?
	ires that the d signed by the be detached		Hepatic steatosis		- choon, mg caaco granima	17.4	es 2 No 3 Pro	bably 4 🗸 Unknown
6	w requires to the second of th	Completed by				24a. Was		utopsy findings available completion of cause of
Š	he law te has	шc	li				formed? death?	
2	ysician: The l ysician: The l his certificate l director, page	Be C	25. Was case referred to medical			(Check only one)		
**	VIL Physici r this c al dire	To E	163 2 110	ient 2 🗸 ER/Outpatie		Nursing Home 5	Residence 6 Othe	er:
Objection of Wital Bocorde D	ding Pl h. After funera		27. Manner of Death 1 X Natural 5 Pending		of Injury 28c. Injury at Wor	_	e how injury occurred	
	Atten rector	icati	2 Accident Investigation 28e, Place of	Injury - At home, farm, st	reet, factory, office building, e		(Street and Number or Ri	ural Route Number, City
	pital or Attending Ph ours after death. eral Director: After t	Certification:	Suicide 6 Could not be determined (Specify)			or Town,	State)	
	DIVISION OF VICAL NECOLUS, F.O. BOX 90 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical C	29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of ex	amination and/or investig	curred at the time, date and p gation, in my opinion, death o	ace, and due to the cau	use(s) and manner as sta e and place, and due to t	ted. he cause(s)
	To Wit To	Mec	29b. Signature and title of certifier	l	29c. License number		29d. Date signed (Mo	
	2		after Beaself Mrs		O.C.M.E.		November 23, 2	009
			30. Name and address of person who completed cause of	, ,	Popp Street Baltiman	o MD 21201		
		tate	Melissa Brassell, MD Assistant Medica 31. Date filed (Month, Day, Year) 34. Regist		Penn Street, Baltimor	e, IVID Z IZUT		
	Regis	tate	DEO 0.7 0000 1/2	J. 1900	Red			

State of Maryland / Department of Health and Mental Hygiene

EASTON

4b. City, Town, or Location of Death

-	2	\cap	0	0	
	Reg. No	U	U	フ	

13

4c. County of Death

TALBOT

38998

Physician
/Medical
Examiner

10a State

10e. Street and Number

Director

Funeral

2

Completed

Be

ပ

MARIAN HARRIS KRAUSZ

10h County

TALBOT

NOVEMBER

2009

3:00 AM

Funeral

Director r items 23a or 28a-f sho Pages 1 and 2 should be filed within 72 hours after 6 is marked other than "natural", or traumatic event, the Ward all Even. Health a Department of Health Important: If item 27 any injury or other tr. once.

altimore, Maryland 21215-0036

4a. Facility Name (If not institution, give street and number) WILLIAM HILL MANOR 5. Social Security Number 1 M 2 X F 212-34-2198 Usual Residence of Decedent

76 10c. City, Town or Location

7. Age (In yrs. last birthday)

EASTON

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Months Days 19, 1933 JAN.

MARYLAND

10g. Citizen of What Country? 10f. Zip Code

10d. Inside City Limits 1X Yes 2 □ No

501 DUTCHMAN'S LANE

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 □Yes 2 X If Yes, Give Year or Dates:

College (1-4or 5+)

21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify

14. Race - American Indian, Black, White, etc.

WHITE

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 🕱 No

16b. Kind of Business/Industry

USA

Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)

1 Never Married 2 Married

3 Nidowed 4 □ Divorced

HOMEMAKER

OWN HOME

Specify:

MARION WILSON HARRIS

FRANCES BROWN LOVEJOY

19a. Informant's Name/Relationship (Type. Print) CATHERINE M. KLAKRING/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 FAIR VIEW DR., CENTREVILLE, MD 21617

20a. Method of Disposition

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of CHESTERFIELD CEMETERY

20c. Location - City or Town, State Date

11-17-2009 CENTREVILLE, MD

21. Signature of Funeral Service Licenses

P.A. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Onset and Death

18. Mother's Name (First, Middle, Maiden Surname)

Physician /Medical Examiner

burial-tran

attending physician for use as the buria

cate has been signed by the page 2 should be detached

funeral director,

filled in by

After 1

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within 24 hours at To the Funeral D completely filled it

the

2

Physician/Medica!

2

Completed

Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Immediate Cause (Final

disease or condition resulting in death)

10 Du (or as a consequence of nu

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☑No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

9 Unknown

4 ☐ Pregnant at time of death 9 ☐ Unknown

Due to (or as a consequence of):

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 □Could not be

1 □Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Manth. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. WOOD, M.D., 501 DUTCHMAN'S LANE, EASTON, MD 21601

State Registrar 31. Date filed (Month, Day, Year) NOV 16 2009 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dennis S. Kimmel 2009 November 4:33 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3209 West Liberty Road Carrol1 New Windsor 5. Social Security Number Sex M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours Min Director 212-62-7297 Yrs. 0271671954 55 MD. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo MD. Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3209 West Liberty Road 21776 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sheet Metal Foreman Sagamore Mech. Contract Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Victor Kimmel Dorothy Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryn Kimmel/Wife 3209 West Liberty Road New Windsor, MD. 21776 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 🔲 Donation 5 Other (Specify) Carroll Crematory 11/17/2009 Winfield, MD. 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road 21. Signa u of Funeral Service Licens & Crematory, P.A. Winfield, MD. 21784 art 1. Inter the disease, or complications the shock, in heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Imr. ediate / ause (Final dise 🛥 or ondition resulting in death) orunam Blain Metook Dinysician, Medical Due to (or as a con quence of): Examiner Sequentially list conditions, Examiner Dusito (or as a consequence of) it any heading to in medicause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. , by 23e. Did tobacco use contribute to the cause of death? 1 - es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performed' death? ☐ Yes 2 4 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu

2 WIL 10

> Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

(Check

only one)

RNESID 31. Date filed (Month, Day, Year)

NOV 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Real

strar's Signature

Washington

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

00080763

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rd Westmirster Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Evangelos Kellas, Jr. 10:15a [™] November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 □XM 2 □ F Months Hours Min. 9/20/1940 Director 215-36-1191 69 MD Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD 1 Yes 2 X No Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23127 Raleigh Rd. 21620 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by Page 1 and 2 should be filed within 72 hours after on ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Merchandiser Beverage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George E. Kellas, Sr. Katherine Batchelor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23127 Raliegh Rd. Chestertown, MD 21620 Marion M. Kellas/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) 11/12/09 Chesapeake Cremation Stevensville, MD Signature of Funeral Servi 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one c use on each line Immediate Cause (Final Onset and Death Physician MPL MYEUMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 NO 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Director: After this certificate 2 📉 0 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: A completed

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State Registrar 29a. Certifier

29b. Signatu

only one

30. Name and address of person who completed cau

31. Date filed (Month, Day, Year) NOV



of death (Item 23a) (Type, Print)

Certifying Nurse Reactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated